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Interview Skills Consulting

GUIDE TO CT, ST & REGISTRAR INTERVIEWS

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0 Introduction

Over the past few years, medical interviews have become increasingly competitive. This is especially true for entry into core training (CT) or specialist training (ST). In addition, the interview process itself has become more arduous, with the traditional "sophisticated chat" in front of a panel being replaced by a rotation between a wide range of stations, with often strict marking schedules and limited time to answer. With systematic preparation, everyone can do very well. However, achieving the success you seek will require a number of conditions to be fulfilled:

Know yourself well

Before you can convince a stranger that you are the candidate that they are looking for, it makes sense to convince yourself. An interview is as much about making bold claims such as "I am a good doctor" as it is about proving it with facts. The truth is that most candidates have not really thought about what they can offer; as a result, they often come unstuck when asked for evidence to support their claims.

One student once asked me how she should answer "Why do you want to train in chemical pathology?" I asked her why she was interested in chemical pathology, to which she replied that she did not know. Somehow, she felt that there was a "miracle answer" which would guarantee her the job and that, if she mentioned three reasons fed to her, she could make it. An interview is *your* personal story, *your* experience, strengths and weaknesses; it is not about regurgitating a ready-made answer. So, you must give yourself time to brainstorm your skills and experience. Throughout this book, I will show you how you can achieve this.

Learn, understand and apply key communication frameworks

A relatively small part of the interview process is about knowledge – in some interviews, clinical or factual knowledge is not tested at all. Interviews are mostly a communication exercise where you are expected to demonstrate your suitability in a mature, enthusiastic and confident manner. To achieve this painlessly, you must acquire a good understanding of some of the fundamental pillars of communication. Like the mental or paper-based frameworks and checklists that you use when you take a history from a patient or perform a procedure, there are techniques you acquire and can use and adapt to your circumstances in order to build confident interview answers.

Throughout this book I will show you how to apply a wide range of techniques to structure your answers and illustrate them with personal examples. By applying these techniques to your personal skills, experience and opinions, you will be able to present powerful and confident answers, whilst at the same time remaining (or appearing) spontaneous.

Practise, practise, practise

I often compare the preparation for an interview to the preparation that comedians or politicians must go through for a new routine or speech. Although everything they say sounds off-the-cuff, it has been carefully thought through and practised. Good interview candidates sound genuine, unrehearsed and enthusiastic; but, although for some lucky individuals this comes naturally, many will have spent time practising and refining their content and technique. This book will show you how to prepare effectively, whether you are one day, one month or further away from your interview date.

By reading the book, you will quickly come to the realisation that, although you could be asked hundreds of questions, you will always get back to the same handful of themes and communication techniques. It is therefore crucial that you do not try to learn answers to each individual question but, instead, that you concentrate on developing good overall personal knowledge of the topics that are being addressed and of the techniques needed to organise and illustrate your answer. This will give you greater flexibility and a definite ability to cope with pretty much any question.

1 Structure of the interview

The structure of the interview varies with each LETB[1] and specialty. Interviews typically consist of a succession of 10-minute sessions at three or four stations, each dealing with different topics. There are variations: some interviews have fewer stations, with more time spent at each; other LETBs have more (up to six). A few have kept the old interview format, i.e. a 30- to 45-minute interview with only one panel. In addition, some specialties/LETBs are very strict on time whilst others are less rigid.

Before attending your interview, make sure that you know the format adopted for your specialty in that LETB – this will influence the way in which you will need to respond. If the interviewers are allowing 10 minutes for five questions, including the time that it takes to ask the question, then you know that you must provide answers that fit within a 90-second timeframe. This means that you must be more regimented and concise in order not to exceed your time.

The stations used at interview can be split between:

- Formal stations (i.e. those designed as a traditional, formal question and answer session); and
- Practical stations (i.e. those which require a more hands-on approach from the candidate – including role play or clinical skills).

On the next few pages, I have set out the different types of stations that you can expect to meet at your interview.

1.1 Formal interview stations

Formal interview stations comprise two or three interviewers asking pre-determined questions of a candidate and scoring the responses. The stations below are those that are commonly found at CT and ST/ Registrar levels.

Portfolio station
The portfolio station can be formal or informal. In some LETBs it is strictly marked, as part of the interview process, whilst in others it is just a chat to ensure that you have matched the required entry criteria. In formal portfolio stations, you may be asked to summarise your experience in 30 seconds, 2 minutes or 5 minutes, to talk about yourself or go through your CV. The interviewers may also pick on specific areas of your training, asking you to describe in more detail what you did. They may use this opportunity to verify your achievements, i.e. courses, publications or research – bring evidence to support the claims made in your application form.

Motivation, interpersonal skills and NHS issues station
This station deals with your reasons for choosing a specialty or this particular LETB, as well as your communication, team playing and leadership skills. Questions may be general or may ask for specific examples. You may also be asked questions on NHS hot topics relevant to the specialty for which you are being interviewed. In some interviews, NHS issues are addressed at the academic station.

Academic station
The academic station is designed to test your understanding and experience of teaching, research and audit. Questions can be:

- Factual (e.g. “Describe your experience of the audit process”, “How do you critically appraise a paper?”)
- Reflective (e.g. “What did you gain from your research experience?”)
- Probing (e.g. “Do you think that all trainees should do research?”).

[1] Local Education and Training Boards – formerly known as ‘deaneries’

You may also be asked to critically appraise a paper for which you will have been given anything between 20 and 45 minutes to prepare. Alternatively, you may be asked to discuss a paper you have read recently (make sure you have one you are able to summarise).

If you have undertaken your own research, be prepared to discuss the details and everyday relevance of your publications and thesis.

Clinical governance station
Questions usually revolve around one or more of the following topics:

- Your own understanding of clinical governance and how it affects your practice (e.g. “What do you understand by the term clinical governance?”, “How does clinical governance impact on your daily practice?”)
- Evidence-based medicine and guidelines (e.g. “What is evidence-based medicine?”, “Tell us about a recent paper that you have read”, “Tell us about a recent guideline published for this specialty”)
- Risk management (e.g. “Tell us about a recent mistake that you have made”, “What happens to critical incident forms once you have submitted them?”)
- Audit, teaching, research if not already addressed in a separate academic section.

Dilemmas/difficult scenarios station
This station is designed to test your ability to handle difficult problems and dilemmas in the workplace. Questions can take different forms and past interviews have included the following:

- Dealing with two or more important matters at the same time (common in medical interviews, e.g. “you are dealing with an emergency on the ward and you are then called to review another patient urgently on a different ward. How do you prioritise and handle the situation?”)
- Dealing with a task for which you are not fully qualified (common in surgical interviews, e.g. “You are in the middle of a surgical procedure and a complication develops. You need to do another procedure, which you have only observed once. What do you do?”)
- Dealing with a lack of integrity (for all specialties, e.g. “Your consultant turns up drunk on the ward one morning. What do you do?”)

Different specialties and LETBs may structure the stations differently. For example, in 2012, some specialties had only one formal station but it dealt with questions relating to motivation, skills and experience, teamwork, audit and integrity. In many medical specialties, academic and clinical governance questions are often grouped together in one station. The actual structure of the interview matters little. You need to prepare for every type of question regardless of the order in which they are asked.

1.2 Practical interview stations

Practical stations require a much more physical or hands-on involvement from the candidate. In the past they were fairly common in Obstetrics & Gynaecology, Psychiatry and Paediatrics, but nowadays they can be found in almost every specialty.

Communication station
This is more commonly referred to as “role play” or “simulated patient consultation”. You are given a small amount of time (5 to 10 minutes) to read a brief, followed by a 10-minute consultation with a patient. The patient is normally played by an actor, though in some cases it has been known to be played by one of the interviewers. Communication stations deal very specifically with your approach to the patient and the problem rather than your clinical skills, which account only for a small portion of the mark.

Presentation station
This station consists of a short presentation (5-10 minutes), often followed in some cases by a question and answer session (also usually 5-10 minutes). In some cases, the topic is given to the candidate on the day (candidates would typically have 45 minutes to prepare); in other cases candidates are given the topic a few days in advance.

Past ST presentation topics have included:

- Generic ("Why would you make a good specialist?")
- Political ("How are current changes affecting the specialty?")
- Personal ("What interests you outside of medicine?").

Chapter 16 details how to handle the presentation station.

Group discussions
Candidates are placed in groups of three or four and are given a topic that they need to debate as a group for usually 20 minutes. There are different types of group discussions, including:

- Simple group discussion around a topic such as a hot topic, how to organise a specific event, etc. In some cases, the discussion can revolve around a document that candidates will have been asked to read before the assessment (e.g. a letter of complaint, a fact sheet relating to a new drug, or even an academic paper)
- Role-based group discussion, where each candidate is playing a different role (e.g. SHO, nurse, manager, patient representative) and must argue their case in relation to a common problem.

OSCE (Objective Structured Clinical Examination) station
This assesses your clinical skills (if not already assessed in a separate scenario station). In such a station, you may be asked to examine a patient, take a history or demonstrate a procedure. You may also be asked about the management of specific clinical situations.

Recent examples have included:

- Orthopaedics: naming specific bones handed out at the interview
- Surgery: suturing orange peel or tomato skin
- Anaesthetics: intubating a dummy.

In view of the wide range of specialities, possible clinical scenarios and the practical nature of this station, it would be impossible to deal with this station in a book on interview skills. If you are competent to an appropriate level in your job and can think laterally then you should have no problem in demonstrating your skills in a viva situation and in answering any clinical questions thrown at you. If you have any doubts about your own clinical skills, you may wish to revise using appropriate clinical books and handbooks.

2 Selection criteria

Medical interviews are organised in a "structured" format. Essentially, this means that interviewers are not simply having a general discussion with you (this would be the "unstructured" format that characterised some of the old-style medical interviews), but that they have set out a range of questions designed to test specific skills and competencies. Through the complexity of the interview process, the interviewers will really be assessing three key areas:

- ***Are you competent enough to do the job?*** I.e. do you have the right skills and experience
- ***Do you have the right attitude?*** I.e. do you have the enthusiasm, motivation and drive to be successful in that specialty?
- ***Will you fit in?*** I.e. do you have a personality that will help you get on well both with patients and colleagues in that specialty?

By the time you get to the interview, some of these areas will already have been partially tested through the application form or your CV. The purpose of the form and CV is to act as a first point of selection by looking at the defined essential and desirable criteria. These criteria are detailed in the Person Specifications on the MMC website and are scored according to the scheme in the application pack – this decides the shortlist of candidates for interview.

The appointment committee will use the interview process to determine whether you have the right approach towards your work and a suitable personality. To excel at your interview, you will need to understand the criteria that will be tested so that you can tailor your answers accordingly and ensure that you hit the mark every time.

To gain that understanding, you will need to read two important documents which set out the behaviours and competencies that interviewers will be looking for:

- The National Person Specification of the post for which you are applying.[2]
- The GMC's *Good Medical Practice* (2013).[3]

We discuss both documents over the next few pages and demonstrate their importance throughout the book.

2.1 National Person Specification

The skills and competencies tested throughout the interview process are set out in a document called the "National Person Specification". Each specialty has its own National Person Specification for each grade. They are made available to candidates with the application form on the MMC website[4] and on individual LETB websites.

The most important part of the National Person Specification for your interview is the section called "Selection Criteria", which summarises the criteria used by the interviewers at the interview. Criteria may vary slightly from grade to grade and from specialty to specialty to reflect the differences in the nature of the work and type of client contact.

We have summarised below those most commonly found and how they may be tested at your interview. For a fully accurate picture, you should read in detail the National Person Specification relevant to the job for which you are applying.

[2] www.mmc.nhs.uk
[3] http://www.gmc-uk.org/guidance/good_medical_practice.asp
[4] www.mmc.nhs.uk

CLINICAL SKILLS

Clinical knowledge & expertise
- Appropriate knowledge base and ability to apply sound clinical judgement to problems
- Able to prioritise clinical need
- Works to maximise safety and minimise risk

Personal attributes
- Shows aptitude for practical skills, e.g. manual dexterity and hand-eye coordination

At the interview, this may be tested by asking you:

- to describe a difficult case that you have managed
- to describe a situation where you had to prioritise clinical needs
- to explain how you would resolve a specific clinical situation
- to prioritise a number of events (e.g. multiple emergencies)
- to analyse test results or images and to describe the next step in the management process
- to demonstrate a given practical skill (e.g. suturing, intubation)
- to demonstrate your understanding of risk management.

ACADEMIC / RESEARCH SKILLS

Research and audit
- Demonstrates an understanding of the principles and/or importance of research and audit
- Demonstrates an understanding of evidence-based practice
- Evidence of active participation in audit
- Evidence of relevant academic and research achievements

Teaching
- Evidence of interest and experience in teaching

At the interview, this may be tested by asking you:

- to discuss the importance of your research and audit experience
- to explain the difference between audit and research
- to demonstrate your understanding of the audit cycle
- to discuss the usefulness of audit in clinical practice
- to debate the role of research in medical training
- to summarise and analyse a paper that you have read recently
- to explain the principles underlying evidence-based medicine
- to explain research governance or statistical concepts
- to summarise the extent of your teaching experience
- to debate the efficacy of various teaching methods.

JUDGEMENT UNDER / COPING WITH PRESSURE

- Capacity to operate effectively under pressure and remain objective in highly emotive/pressurised situations
- Awareness of own limitations and when to ask for help
- Demonstrates initiative and resilience to cope with changing circumstances

At the interview, this may be tested by asking you:

- to discuss how you handle stress
- to provide an example of a situation where you were stressed
- to explain how you would handle a given stressful scenario

- to give an example of a mistake that you have made
- to talk about a recent situation where you had to ask for senior help or where you felt out of your depth
- to describe a situation where you had to make decisions in a changing environment
- to talk about your weaknesses
- to discuss how you deal with criticism.

COMMUNICATION SKILLS, EMPATHY & SENSITIVITY

Communication skills

- Capacity to communicate effectively and sensitively with others, and ability to discuss treatment options with patients in a way they can understand
- Capacity to adapt language as appropriate to the situation
- Ability to build rapport, listen, influence and negotiate

Empathy *& sensitivity*

- Capacity to take in others' perspectives and treat others with understanding. Sees patients as people

At the interview, communication skills may be tested in different ways. First, the interviewers will be testing your communication skills throughout the interview by assessing how you relate to them, the manner in which you present your answers and how you structure arguments. They will also pick up on non-verbal communication such as your body language, the appropriateness of your tone of voice and the confidence that you exhibit when delivering your answers.

In some specialties, your communication skills, empathy and sensitivity may also be tested through role play (e.g. asking you to explain the management of a condition, to break bad news or to reassure someone) or through a presentation (which will be testing your general communication and teaching skills more than your empathic and sensitive nature).

Finally, you may also be asked direct questions on communication, for example:

- to explain a complex issue in lay terms (e.g. in Ophthalmology, some were asked to explain in lay terms what glaucoma was)
- to describe or rate your communication skills
- to give an example of a situation where your communication skills made a difference to the care of a patient
- to give an example of a situation where you had to deal with a conflict, a difficult colleague/ patient or a vulnerable patient
- to describe how you would handle a situation where one of your colleagues is underperforming.

PROBLEM SOLVING & DECISION MAKING

- Capacity to use logic and lateral thinking to solve problems and make decisions
- Ability to think beyond the obvious, with a flexible mind
- Capacity to bring a range of approaches to problem solving
- Effective judgement and decision-making skills

At an interview, this may be tested by asking you:

- to provide an example of a difficult case that you managed
- to discuss a situation where you had to make a difficult decision (e.g. without senior support)
- to give an example of a situation where you showed initiative
- to describe how you would deal with a difficult given clinical situation.

Problem-solving skills are often tested through clinical questions. In some cases, they may also be tested by discussing difficult scenarios or professional dilemmas.

MANAGING OTHERS, LEADERSHIP & TEAM PLAYING

- Capacity to work effectively in a multidisciplinary team and demonstrate leadership when appropriate
- Capacity to establish good working relations with others
- Ability to supervise junior medical staff

At an interview, this may be tested by asking you:

- to explain what makes you a good team player or team leader
- to provide examples where you have played an important role in a team or where you have shown good leadership
- to detail your experience of working in teams
- to explain what makes a good team and to discuss the advantages and disadvantages of working in teams
- to provide an example of a situation where you had to deal with a difficult situation at work
- to detail your experience of managing others
- to discuss the difference between management and leadership
- to discuss how you delegate and/or to provide examples of delegation and management.

ORGANISATION & PLANNING

- Capacity to manage/prioritise time and information effectively
- Capacity to manage time and prioritise workload, to balance urgent and important demands, and to follow instructions
- Capacity to organise ward rounds
- Understands importance and impact of information systems
- Relevant IT skills

At an interview, this may be tested by asking you:

- to explain how you manage your workload or your time
- to provide an example of a situation where you had to prioritise
- to prioritise a list of five or six emergencies or other tasks
- to explain how you would organise a ward round, a theatre list or a training session
- to detail your IT experience and explain its relevance.

VIGILANCE & SITUATIONAL AWARENESS

- Capacity to monitor developing situations and anticipate issues
- Capacity to be alert to dangers or problems, particularly in relation to clinical governance
- Demonstrates awareness of developing situations

At an interview, this may be tested by asking you:

- to provide an example where you showed initiative
- to provide an example of a time when you had to remain vigilant
- to describe a situation when you resolved an unsafe situation
- to explain how you ensure that you remain fully aware of what is happening in complex clinical situations
- to discuss how you would handle a given clinical scenario (e.g. ALS).

2.2 GMC Guidance

The GMC's *Good Medical Practice* (2013)

This guidance document sets out the responsibilities of all doctors towards society, their patients and their colleagues. It can be found on the GMC's website (www.gmc-uk.org) and I encourage you to read it before you undertake any preparation as it will crystallise a number of important concepts in your mind.

It is crucial that you spend 30 minutes reading *Good Medical Practice* (2013) attentively on the GMC's website or in the booklet that you should have received from the GMC since, at the interview, you will be expected to demonstrate your understanding of its principles, be it through the provision of examples based on your personal experience, by answering theoretical questions or by discussing difficult scenarios. We will see throughout this book how we can make full use of all this information to transform it into pragmatic, well-structured, well-argued, spontaneous and personal answers.

Other useful guidance

There are, of course, many guidance documents that you will need to be aware of in the course of your career. However, in preparation for your interview, you may want to give priority to the following:

- *Raising and acting on concerns about patient safety* (2012)[5]
- *Confidentiality* (2009)[6]
- *Consent: patients and doctors making decisions together* (2008)[7]

If you are applying for paediatrics or are generally likely to work with children, you may also want to read *0-18 years: guidance for all doctors.*[8]

[5] www.gmc-uk.org/guidance/ethical_guidance/raising_concerns.asp
[6] www.gmc-uk.org/guidance/ethical_guidance/confidentiality.asp
[7] www.gmc-uk.org/guidance/ethical_guidance/consent_guidance_index.asp
[8] www.gmc-uk.org/guidance/ethical_guidance/children_guidance_index.asp

3 Marking scheme

ST interviews are structured. This means that each question has a specific purpose: to test one or more given skills or competencies. Your answer is then assessed against a range of criteria and marked. This makes it possible to compare candidates in a systematic and objective manner. In essence the rationale behind this design is to make the process fairer; it avoids interviewers drifting down a line of personal interest or grilling candidates unfairly. However, as we will see, there is still room for subjectivity on the part of the interviewer.

The use of a structured marking scheme and the attempt to make interviews more even-handed has led some candidates to assume that there is a "right" answer to questions. That is usually not the case. Interviewers are viewing you as potential long-term colleagues. It is important that you are safe and that you have a good understanding of basic information. To score highly in an interview you will need to be capable of intelligent conversation around issues. This is not possible without the ability to develop and discuss your own opinions and use relevant examples.

Positive and negative indicators

For each question, the interviewers are given a list of positive and negative indicators. Positive indicators are behaviours that one would expect from a suitable candidate. Negative indicators are behaviours that would be cause for concern. For example, if the question is "One of your colleagues is underperforming; what do you do?", the indicators would be along the following lines:

Positive indicators	Negative indicators
▪ Considers impact on patient safety ▪ Considers the impact on the team and the colleague ▪ Remains open-minded. Does not judge or jump to conclusions ▪ Involves appropriate support from/reports appropriately to senior colleagues ▪ Adopts a supportive and constructive approach	▪ Does not consider impact on patient safety or on the team ▪ Compromises patient safety ▪ Handles the problem alone ▪ Focuses on reporting without measuring the implications on the colleague ▪ Does not involve appropriate team members ▪ Judgemental and unsupportive

Similarly, for the question "Describe an example of a time when you had to deal with pressure", positive and negative indicators may be as follows:

Positive indicators	Negative indicators
▪ Demonstrates a positive approach towards the problem ▪ Considers the wider needs of the situation ▪ Recognises own limitations ▪ Is able to compromise ▪ Is willing to seek help when necessary ▪ Uses effective strategies to deal with pressure/stress	▪ Perceives challenges as problems ▪ Attempts unsuccessfully to deal with situation alone ▪ Uses inappropriate strategies to deal with pressure/stress

If the interviewers feel that there are areas that you have failed to address, they may help you along by probing appropriately.

For example, in answering the question above "Describe an example of a time when you had to deal with pressure", if you focused on how you dealt with the practical/clinical angle of the problem but you forgot to discuss how you managed your stress during and after the event, the interviewers may

prompt you with a further question such as “What did you find particularly stressful at the time and how did you handle it?” This would give you an opportunity to present a full picture of your behaviour.

Positive and negative indicators can be imposed centrally (in which case all applicants to the same specialty are judged according to the same indicators, wherever they apply). However, in some cases, each local panel is required to come up with its own positive indicators, which can make the process inconsistent across LETBs.

Marking schedule

Based on the above positive and negative indicators, the interviewers will mark the candidate’s performance on a scale of 0 to 4. The marking schedule that is most often used is as follows:

0	No evidence	No evidence reported.
1	Poor	Little evidence of positive indicators. Mostly negative indicators, many decisive
2	Areas for concern	Limited number of positive indicators. Many negative indicators, one or more decisive
3	Satisfactory	Satisfactory display of positive indicators. Some negative indicators but none decisive
4	Good to Excellent	Strong display of positive indicators. Few negative indicators, all minor

This schedule clearly sets a number of criteria in relation to positive and negative indicators. Note that the schedule introduces the concept of “decisive negative indicators”. Decisive negative indicators are those which carry a stronger weight than normal because they relate to fundamental problems.

For example, taking an approach that is unsafe for patients would count as a decisive negative indicator. Failing to report a colleague who is endangering patients would also count as a decisive negative factor. In some marking schedules, matching a decisive negative indicator could score you an automatic 0 out of 4. In some interviews, scoring a zero with a decisive negative indicator may trigger an automatic failure of a station or, possibly, the whole interview.

Throughout this book, I will discuss the positive and negative indicators for a wide range of questions. This will give you a good insight into what is expected of you; it will also teach you to work out those indicators by yourself when faced with a question that you did not prepare for or expect.

4 Key interview techniques

Interviews are all about conveying information in a convincing and confident manner. They are therefore, primarily, a communication exercise. It is important that you understand and respect some key principles, which will enable you to present meaningful and confident answers.

Keep your answers between 1½ and 2 minutes

No one can listen to a speaker for more than 2 minutes unless that speaker is absolutely fascinating or has some visual aids to help retain concentration. There is therefore no point in giving answers that are much longer as you run the risk of boring your interviewers.

The only exceptions are open-ended questions, which involve presenting a lot of information (e.g. "Tell us about yourself", "Take us through your CV", "Tell us about your research experience" if you have a lot of it). These may take slightly longer, but you should avoid answers longer than 3 minutes – if you can.

In some (rare) cases, the length of your answers may be strictly dictated by the interviewers. In some specialties, the interview stations last exactly 10 minutes and involve five questions. Allowing for the time taken to ask a question and for interviewers to mark your answers, this leaves about 1½ minutes in which to give an answer. In such cases, the time restriction is usually clearly advertised at the beginning of the process. Make sure that you read carefully any information sent to you prior to the interview.

Make sure also that you consult the appropriate Royal College and LETB websites (see chapter 19) as some LETBs and colleges publish crucial information, including the marking scheme, both for the application and the interview.

Avoid long introductions – answer the question directly

In my experience of interviewing and coaching candidates for interviews, I am often struck by how few people actually answer questions directly. During an interview, it is crucial that you get to the point quickly, address the core of the question and avoid lengthy introductions serving no purpose other than to buy you time.

For example, a typical candidate would start answering a question such as "Tell me about your experience of clinical governance" with the following words "Clinical governance is a framework whereby all organisations …", i.e. by the most common definition. In fact, this does not answer the question. The question is asking for your experience, not a definition or your understanding of governance.

The answer to this question should really start with something along the lines of: "Clinical governance is something that I am involved with on a daily basis. For example, etc…" It is a golden opportunity to showcase how you use tools such as audit, teaching and risk management in your day-to-day practice; do not waste it by reciting a definition – anyone can do this and many will.

Similarly, whenever I have asked someone "How would you describe your communication skills?", the answer has inevitably been: "Communication skills are important in my job because in my specialty we need to communicate every day with a wide range of people, and without communication we cannot be successful. In my day-to-day work I communicate with senior colleagues, junior doctors, nurses, GPs, doctors from other specialties, etc…" Again, this does not answer the question at all.

The candidate is being asked to describe their own communication skills, and not to discuss the importance of communication and the job titles of those to whom they talk. This is not to say that it is totally irrelevant; indeed, such information may have a place in the final answer, but using it at length right at the start of the answer will irritate the interviewers. Instead, the candidate should talk about how good they think they are, the aspects of communication they are particularly good at, and the feedback they have received.

The answer should start much more directly, with something like: "I feel that I have good communication skills and the feedback that I have received both from my patients and my colleagues has been extremely positive." This would then be followed by three or four points setting out the candidate's strengths in communication.

As a rule it is sensible to avoid using abbreviations – even familiar ones. From a communication point of view they can sound sloppy and lazy. You may also confuse members of your panel – especially if there are lay members present.

Structure your answers in three or four points

A problem that plagues candidates is the lack of structure in their answers. This makes it difficult for the interviewers to identify easily what the candidate is getting at. The human brain finds it difficult to remember more than three or four ideas at a time; so there is no point in giving your interviewers ten different ideas in the same answer. You will struggle to recall them and it will only confuse your panel. Stick to three or four points maximum. If you feel you need more than four points to say what you want to say, then see if you can structure your answer in a different manner.
For example, the answer to "Tell us about your teaching experience" can be structured as follows:

- Who you have taught, what you taught them and how often
- Which teaching methods you have experience of
- Teaching courses you have attended
- Feedback you have received.

The answer to "Tell us about a mistake that you have made" can be structured along these lines:

- Description of the scenario and the mistake made
- How you dealt with the mistake at the time
- What you learnt from the incident/how it changed your practice
- How you made sure others learnt too (including critical incident reporting)

The answer to "What are your main strengths?" can be structured using three personality traits, which are sufficiently different to justify being placed in different sections. For example:

- Dynamic and proactive
- Approachable and supportive
- Self-starter and constantly willing to learn and develop.

Each of the points can then be developed individually. The clear and succinct structure will leave no doubt as to where you are going with your answer. Not only will a strong structure enable the interviewers to understand what you are saying without putting in too much effort, it will also make you sound much more direct, engaging and confident.

Expand on each point and illustrate with examples

It is all too easy to quote a few buzzwords and to think that they will be sufficient to tick all the right boxes. For example, many candidates answer the question "What makes you a good doctor?" with the following one-liner: "I am a good doctor because I am hardworking, motivated, dedicated, focused, a good communicator, a good team player, I learn from experience and constantly seek to develop new skills". None of these words are wrong and indeed, strictly speaking, this sentence answers the question asked. However, a succession of buzzwords can make the answer sound clichéd and impersonal. In fact, every candidate could give the same answer regardless of their grade and specialty.

Making broad statements makes you sound vague (and possibly arrogant); it also makes it difficult for interviewers to positively differentiate you from other candidates. It is therefore crucial to back up any claims you make with examples drawn from personal experience; this will leave no doubt in anyone's mind about your abilities.

For example, "I learn from experience and constantly seek to develop new skills" is an easy statement to make. Once you have made this statement, you could recall briefly one or two examples where this happened, as follows:

"From the very beginning of my training, I have taken every opportunity to learn from and build on my experience. For example, recently I had trouble getting a patient to agree to a procedure and with the help of my registrar I learnt to take a different communication approach which I have now incorporated into my practice.

Whenever I encounter clinical situations with which I am less comfortable than others, I take the time to read up on it and in fact often volunteer to run teaching sessions on those difficult topics. Recently I have identified that a couple of local guidelines were no longer appropriate and I volunteered to update them.

During that process, I learnt a lot not only about how to conduct literature reviews, but also how to communicate with colleagues, as some members of the team showed a reluctance to change their established practices.

Following on from that, I took it upon myself to attend a Trust-run management course and I have since taken on other projects such as <xxx>."

Bringing examples into your answers makes you sound more mature and practical; it also enables you to discuss other skills. For example, the answer above brings in management and leadership and shows that you are in control.

Signpost each point clearly – make your points clear

Signposting means stating clearly the new concept or idea that you are addressing. Many candidates have answers that are well structured and contain a lot of interesting information backed up with good examples; however, in spite of this, it can still be difficult to extract the message or idea they are trying to communicate from their answer. This section aims to help you to clarify your message. Once you have a structure in mind, make sure your key messages are announced clearly within each section of your answer. These may be introduced in a number of ways, as illustrated below.

- **Signposting at the start**
  Signposting is more easily done at the start of each section. For example, an answer to the question "Why do you want to train in surgery?" could consist of three sections signposted as follows:

Introduction	"There are many reasons why I am keen to train as a surgeon.
Signpost & Expand	First, I draw a lot of personal satisfaction from being able to make an immediate difference to my patients. <Then explain why and how, bring examples>
Signpost & Expand	As well as this, I also have a strong interest in research and I feel that surgery is an excellent specialty in which to pursue that interest. <Then expand explaining what the interest consists of and how this relates to a career in surgery>
Signpost & Expand	Finally, I really enjoy working under pressure and in close cooperation with other colleagues." <Then expand on how this is important in surgery and what you enjoy about it>

  In this example, each section starts with a clear message, which is what the candidate wants the interviewers to remember about him/her.

- ***Signposting at the end***
  Signposting can also be done at the end of each section of an answer. In this case, the candidate would typically start the section with a description of his experience and would then conclude by

explaining how this is relevant to the question asked. For example, for the question "Why do you want to train in surgery", instead of stating up front that he/she has a strong interest in research, the candidate could phrase the answer as follows:

Context/Experience	"During my attachment in Orthopaedics I had an opportunity to become involved in two research projects, one which was on <xxx> and another one on <yyy>. Through my involvement in these projects, I gained a good insight into different research methodologies and the importance of research overall, and I discovered that I felt very much at ease both in the clinical and the academic setting.
Signpost/Message	I feel that surgery is a field that will provide an ideal opportunity to apply both my clinical and academic skills to patient care."

This would then be followed by two more sections dealing with other reasons for choosing surgery as a career. In this example, the message is clearly stated in the last sentence, leaving the interviewers with no ambiguity as to what the candidate is trying to say.

- ***Vary the signposting***
  Beginning all sections of all answers with a signpost is likely to make you sound slightly "military" or overly systematic. Signposting all sections at the end may give the feeling that you are constantly trying to build suspense and drama in your answers.

  If you can, i.e. if you feel confident enough to do so, try to vary the way in which you signpost so that some of your answers have points that are signposted at the start and others at the end. This will give a more balanced picture and will be easier on the ear of your panel.

  However, if you do not feel able to vary your answers in this way, stick to signposting at the start. It is the easier of the two to master. Once you feel more comfortable, you can start experimenting and softening your delivery by mixing the two styles.

Use power words and active verbs

Selling yourself is not just about stating your message clearly and describing your experience. It is also about sounding confident, mature and, generally speaking, in control. It is a common mistake for candidates to understate their experience. In order to appear more confident, you will need to adopt a vocabulary which may be slightly different to that which you are accustomed to on a day-to-day basis, and which will sell you in an active and enthusiastic manner.

There is no need to learn a whole list of words in order to achieve this. When you are preparing your answers to some of the more common questions, particularly those based on your personal experience, you should question whether your answers sound energetic and enthusiastic enough. If they don't, this could be a problem with the structure or a lack of personalisation in your answer; but it could also be due to the lack of power words and active verbs.

Example
Consider this sentence: "After a few attempts, I was able to reach a compromise with my colleagues."

On the surface, it sounds like a good thing to say. However, "After a few attempts" and "I was able to" sound weak. They make it sound as if the candidate didn't try that hard or is not particularly proud of their achievement.

The sentence could have a much stronger impact if it were reworded as follows: "Following several discussions where I encouraged my colleagues to review their position, I was successful in helping the team reach a compromise." In this revised sentence, the words "encouraged" and "successful" present a much more proactive candidate and make a big difference in the manner in which the answer is being received by the listener.

Talk about yourself, rather than everyone else

Candidates who feel uncomfortable at interviews usually compensate by talking about everything else but themselves. They talk repeatedly about “we” and “the team” and, although it does present a good team-playing attitude, it fails to demonstrate their personal skills and competencies.

In your interview, it is perfectly acceptable to introduce some collective actions and make statements such as “As a team, we were charged with conducting an audit on waiting times in A&E”. This sentence should only serve as an introduction to the rest of the answer, which then remains focused on you and no one else with the use of “I”, “My responsibilities”, “My aim”, etc.

Bring objectivity into your answers

If you feel awkward talking about yourself or don’t want to appear boastful, a good way to overcome this problem is to bring objectivity into your answers. This can be achieved by:

- Illustrating your answers with personal examples and
- Mentioning feedback that you have received, either informally or through 360-degree appraisal.

Instead of “I feel that I am an excellent listener”, you may feel more comfortable saying “My patients and colleagues have often commented on the fact that I am a very good listener.”

Avoid making vague statements

Keep to statements that provide definite, factual information. Avoid vague statements such as “I went into surgery because I like it” unless you can back up your statement. What really matters is why you find it interesting or why you like it. Use facts to substantiate your general statements. Use the 5 “W” questions (what, who, where, when, why) and the “H” question (how) to gain knowledge about yourself and add content.

Avoid unnecessary detail

Avoid excessive detail when giving examples unless you have been asked for specifics. If you provide too much intricate detail, your answer will be very long and wordy. Most importantly, you will distract from your key message by concentrating on one issue whilst the question may be much broader.

Remain positive

Whether I coach people who are applying for CT, ST, Consultant, Clinical or Medical Director posts, or even higher up, candidates incriminate themselves by delivering answers with a negative undertone right from the start. I have lost count of the number of people who start their answers to the question “What is your research experience?” by saying “Well, I haven’t done much research”; or those who describe their communication skills as “above average”, i.e. nothing special. To make an impact, you must sell what you have rather than what you don’t have. If you don’t show that you believe in yourself then no one else will.

5 Key interview structures

In order to produce structured and meaningful answers, you will need to learn to use a number of structures and frameworks that will make your life easier. Once you have mastered these, you will be able to apply them endlessly across a wide range of questions. Not only will this give you a sense of direction, it will also provide you with reassurance as you deliver your answers. You will feel more in control because you will know that there are sound principles that you can apply, regardless of what the question is.

In this section, we introduce three fundamental structures:

- **CAMP**: for background and motivation questions
- **STAR**: for skills-based questions asking for specific examples
- **SPIES**: to answer questions on difficult colleagues or conflicts.

Make sure that you do not simply memorise these techniques but that you learn to use them intelligently – the next level beyond the use of acronyms to simply remember, for example, the cranial nerves or branches of the internal iliac artery. At the interview, you are likely to feel nervous and to blank out if you simply try to recall information. The key to success is to allow sufficient time to prepare so that these structures become second nature and you do not have so much thinking and information-recalling to do on the spot.

Throughout the book, I will apply these key generic structures and will also develop other structures that are more specific to individual questions. More importantly, I will show you how to think about the questions logically and construct answers using your common sense and experience.

5.1 The CAMP structure (for background & motivation questions)

CAMP = Clinical, Academic, Management, Personal

When answering questions such as “Tell me about yourself”, “Take me through your CV”, “Why do you want to train in this LETB?” (for training posts), or any generic question which draws on the breadth of your experience, CAMP will provide you with a ready-made structure that will enable you to provide a logical and well-developed answer.

For example, when answering the question “How do you see your career developing over the next 10 years?”, using the CAMP structure will prompt you for ideas along the following lines:

Clinical	You may want to work in a specific type of hospital (e.g. teaching, DGH, tertiary hospital). You may also want to develop special clinical skills or interests.
Academic	You may have an academic interest and want to develop research interests and skills. You may be keen on teaching and want to get involved in education and training activities. You may even wish to get involved at regional or royal college level, and perhaps undertake a medical education degree.
Management	You may want to gain further experience in areas such as service development, audit, or risk management. Perhaps, even, you are aiming at becoming an educational supervisor or other responsibilities.
Personal	Is there a region where you would like to settle? Perhaps you would like to spend some time abroad to expand your horizons both clinically and socially. Do you have any relevant or interesting hobbies or skills that will make your interviewers want to ask you more?

5.2 The STAR structure (for questions asking for examples)

STAR = Situation, Task, Action, Result/Reflect

The STAR structure is a universally recognised communication technique designed to provide meaningful and complete answers to questions asking for specific examples, such as:

- "Tell us about a situation where you worked under pressure"
- "Describe a situation when you dealt with a difficult patient"
- "Tell us about a time when you played a key role in a team"
- "Describe a situation where you had to ask for senior help"
- "Give an example where your communication skills made a difference to the care of a patient."

Many interviewers will have been trained to use this structure. Even if they have not, they will recognise its value when they see it. The information will be given to them in a structured manner and, as a result, they will become more receptive to the messages you are trying to communicate.

The interviewers will be looking for the following:

Situation	What is the context of the story?
Task	What did you have to achieve?
Action	What did you do? How did you go about achieving it? And why did you do it in that way?
Result/Reflect	What happened at the end? Why did you feel you did well? If the example is about a mistake or a difficult situation, what did you learn? How did it change you?

Step 1 – Situation or Task

Describe the situation that you were confronted with or the task that needed to be accomplished. This section is merely setting the scene for the "Action" section so that your panel can understand the story from start to finish. You should therefore aim to make it concise and informative, concentrating solely on what is pertinent to the story and the message you are trying to communicate.

For example, if the question is asking you to describe a situation where you had to deal with a difficult person, explain how you came to meet that person and why they were being difficult. If the question is asking for an example of teamwork, explain the task that you had to undertake as a team and what your role was.

Step 2 – Action

This is the most important section as it is where you will need to demonstrate that you have the skills and personal attributes that the question is testing. Having set the context of your story, you need to explain the action you took, bearing in mind the following:

- Be personal, i.e. talk about you, not other people
- Go into some detail. Do not assume that the interviewers will guess what you mean
- Steer clear of clinical information, unless it is essential for the general comprehension of the story
- Explain not just what you did, but how and why you did it.

What you did and how you did it
Explain the actions that you took to resolve the situation, highlighting clearly your role. In describing your role, keep in mind the purpose of the question and the skills that it is asking you to demonstrate.

For example, a question asking you to provide an example of a situation when you dealt with a difficult patient will involve discussing a number of points, including:

- How you used your communication skills effectively
- How you sought to involve others in helping you deal with the patient
- How you dealt with your frustration.

Why you did it

If you stick to explaining what you did and how you did it, you run the risk of giving an answer that is slightly too basic. In your answer, you must be able to demonstrate that you are taking actions because you understand their purpose and what they will achieve, not simply because you got lucky.

Never lose sight of the fact that the example is only of interest if you demonstrate through your narration how you match the desired criteria.

Consider the following question and (ineffective) answer:

Question:
"Tell me about a time where you dealt with a difficult patient."

Ineffective answer:
"I was called to Accident and Emergency to review a patient who, I'd been told, was aggressive and abusive towards other patients and even towards members of staff. I came down to Accident and Emergency and took the patient to a separate room. We had a 10-minute discussion during which I was able to resolve his problem. The patient left shortly thereafter and decided not to make a complaint."

This example is very superficial. On the positive side it does follow the STAR structure but, although the candidate has described what they did, there is a distinct lack of detail.

More importantly, we do not know why they acted in this way and what they were trying to achieve. This will make it difficult to mark the candidate appropriately. For example, why did they take the patient to a separate room? By highlighting the reasons behind their reaction, the candidate would make a greater impact, as follows:

Reworded partial answer
"…As I arrived in Accident and Emergency, there were two issues that I needed to address. My main priority was to ensure that the staff and patients who had been abused were unharmed so I asked a senior nurse to look after them. Meanwhile, I was also conscious of the need to take the patient away from the emotions of the situation so that we could have a sensible discussion about the issues at stake. I felt that the best way to address this was to take him to a separate room, taking another colleague with me for my own safety…"

By explaining both what you did and the reasons behind your actions, you bring more depth to your answers and will appear a more mature candidate and consequently score much higher.

Step 3 – Result

Explain what happened eventually: how it all ended. You may be surprised by the number of candidates who finish their answers on a cliff-hanger. By not concluding your story, you will leave the interviewers with a strange sensation and, although they are likely to prompt you for an ending and a reflection, it will sound much better if you come to it of your own accord.

Once you have stated the ending of the story, you can then conclude the answer in two different ways:

- By reflecting on the scenario and explaining the significance of the story to your role as a doctor

Example of an ending for the question: "Tell me about a time where you dealt with a difficult patient."

"…After our discussion, the patient decided not to make a complaint and said that he was actually very happy with the attention that he had received. By focusing my attention on the needs of the patient and the safety of the staff, I was able to redress the situation successfully. This example demonstrated how important simple things like listening can be, and how much can go wrong when communication is not properly handled."

- By summarising the key skills you demonstrated during the scenario

Example of an ending for the question: "Give us an example of a situation where you showed leadership."

"…Throughout this scenario, I showed leadership both by ensuring that all junior members of the team knew exactly what they had to do and that they were supported in their role by my availability if there were problems. I also ensured that my seniors were kept fully up to date with key developments and that we not only took care of the patient's needs but also of the relatives' needs for information and support."

5.3 The SPIES structure (questions on difficult colleagues)

SPIES = Seek info, Patient safety, Initiative, Escalate, Support

Questions asking how you would deal with a difficult colleague come in different shapes and forms. The level of difficulty varies from simple lateness to training-related underperformance and attitude problems, to sheer criminal acts. In these questions, the level of seniority of the colleague in question also varies from a junior doctor to someone more senior, such as a consultant, for example.

Examples of questions frequently asked include:

- "One of your junior colleagues keeps coming in late. What do you do?"
- "What would you do if your consultant came into the ward/theatre drunk one morning?"
- "One of your colleagues keeps turning up 20 minutes late each morning. What do you do?"
- "Your consultant is asking you to do something that you feel is wrong (e.g. modifying notes to cover up a mistake). What do you do?"
- "Your Registrar constantly fails to answer his bleep, leaving you several times in precarious situations. He tells you that his batteries keep going flat. What do you do?"
- "During a break in the mess, you see a bag of cocaine fall out of your Registrar's pocket. How do you handle the situation?"
- "You walk into your consultant's office and see him watching images of child pornography on the hospital computer. What do you do?"

The scenarios are daunting and these questions often strike fear into the heart of candidates – most of us imagine the worst case and the thought of having to remove our drunken boss from the ward. Psychologically, part of the difficulty is to overcome the fear of what would happen to "me" if I blew the whistle. Your interviewers will demand that you understand the broad implications of the scenario not only for patients, but also for the team and for your colleague. They will be testing your ability to address all the relevant issues appropriately. Having the SPIES structure as a basis for your answer allows you to deal with any of the above questions by applying the same principles.

At the interview, you will be expected to demonstrate that you can handle the situation in a responsible and mature manner, ensuring patient safety at all times whilst also resolving the matter sensitively.

To ensure that you cover all angles, you will need to consider the following:

Seek info	Before you can do anything, you need to understand the nature of the problem. In some cases, it will take a fraction of a second (e.g. if a colleague is drunk). In others, it may take longer (e.g. if a colleague does not appear motivated). This may involve discussing the matter with the individual concerned or with other colleagues, if appropriate.
Patient Safety	Once you have assessed the situation, you must make sure that patients are protected. If the person is an immediate threat to patients (e.g. drunk or about to do the wrong operation), then you must remove them from the clinical area or tell them to stop doing whatever they are doing (this could be done by having a quiet word with the individual in question, or in the worst-case scenario calling for help to have them removed).
Initiative	Is there anything that you can do by yourself that will help resolve the problem? In practice, this will only apply to minor issues, where there is no real threat to patient safety. If the colleague is drunk, there is little that you can do to help. However, if it is just an issue of a junior colleague being a bit slow, then there are things that you could do to help out in the first instance (e.g. individual coaching or a discussion).
Escalate	If the situation is too serious for you to deal with, then you must involve other colleagues at appropriate levels of seniority. For a problem junior colleague, this could be the Registrar, the education supervisor of the underperforming colleague or another consultant. For an underperforming consultant, this would need to be the clinical director. If the situation is not resolved, you may need to escalate further to the medical director, the chief executive or even the GMC. If you don't know what to do, you can seek advice from other organisations (e.g. the BMA, any medical defence organisation, the GMC).
Support	There are reasons for the colleague to behave in this way. As an individual he will need support to deal with the problem. Your team will also need support if it is one person down.

This approach is supported by the following articles from the GMC's guidance documents:

Good Medical Practice (2013) – Article 25:
"You must take prompt action if you think that patient safety, dignity or comfort is or may be seriously compromised.

a. If a patient is not receiving basic care to meet their needs, you must immediately tell someone who is in a position to act straight away.

b. If patients are at risk because of inadequate premises, equipment or other resources, policies or systems, you should put the matter right if that is possible. You must raise your concern in line with our guidance and your workplace policy. You should also make a record of the steps you have taken.

c. If you have concerns that a colleague may not be fit to practise and may be putting patients at risk, you must ask for advice from a colleague, your defence body or us. If you are still concerned, you must report this, in line with our guidance and your workplace policy, and make a record of the steps you have taken."

Raising and acting on concerns about patient safety (2012) – Article 12
"If you have reason to believe that patients are, or may be, at risk of death or serious harm for any reason, you should report your concern to the appropriate person or organisation immediately. Do not delay doing so because you yourself are not in a position to put the matter right."

Raising and acting on concerns about patient safety (2012) – Article 13
"Wherever possible, you should first raise your concern with your manager or an appropriate officer of the organisation you have a contract with or which employs you – such as the consultant in charge of the team, the clinical or medical director or a practice partner. If your concern is about a partner, it may be appropriate to raise it outside the practice – for example, with the medical director or clinical governance lead responsible for your organisation. If you are a doctor in training, it may be appropriate to raise your concerns with a named person in the LETB – for example, the postgraduate dean or director of postgraduate general practice education."

Good Medical Practice (2013) – Article 43:
"You must support colleagues who have problems with their performance or health. But you must put patient safety first at all times."

As we will see throughout this book when we study individual questions dealing with problem doctors or difficult colleagues, a lot of the answers call upon your common sense. The SPIES structure is really there to make sure that you do not forget anything crucial in your answers.

6 Background & motivation questions

6.1 Take me through your CV / Tell me about yourself

In answering this question, it is tempting to list your experience methodically. However, this is unlikely to result in a very engaging and enthusiastic answer and would certainly take more than the allocated time to deliver your full biography. The following rules will enable you to provide a comprehensive yet concise and personal answer.

Do not literally take them through the CV

I remember once sitting in on an interview where the candidate actually started his answer with: "Well, on the 1st page, you will find my name, address and qualifications; on the 2nd page, the list of past jobs, etc." Needless to say, the panel was not impressed. Instead of boring everyone with a lengthy description of every page, think of the themes that your CV addresses and of the points that you want the interviewers to remember about you.

Do not worry about overlapping with future questions

Many candidates worry that, if they talk about everything at the start of the interview, they will have nothing else to say later on if they are asked a question on research or teaching, for example. In reality, you simply do not know what questions you will be asked later on, so do not deprive your interviewers of important information on that basis. Treat this question as a contents table for the interview, where you will be setting out what you have to offer in a logical and structured manner, without going into excessive detail.

Avoid the chronological approach

Structuring your whole answer around the chronology of your training to date will create an answer which will feel long and in which you will spend much time listing hospital names, dates and specialty names. Going through every single job you have had so far may be okay if you have very few jobs behind you, but if you have more than five or six then it could prove lengthy. The most effective answers tend to be structured around the main themes of a candidate's experience (i.e. their clinical training, why they enjoy the specialty, their research and audit experience, etc.) rather than the chronology of their training.

Apply the CAMP structure

If your CV is well designed, it will already have been written more or less along the lines of the CAMP structure (i.e. with clinical information at the start; followed by your audit, research, teaching and management experience; finishing with more personal information such as hobbies). There is no reason why the answer to this question should vary widely from the actual structure of your CV. You simply need to convert it into something that is easy to listen to. Here is an example of how you could structure your answer:

Clinical
- Brief chronology of your training (15/20 seconds)
- Description of skills and experience (2 to 4 points)
- How this motivated you for this specialty/post, or why you want to train in this specialty.

Academic
Brief description of your research/teaching involvement, including:
- Papers you have written
- Relevant postgraduate qualifications
- Postgraduate courses you have been on
- Teaching you have done, teaching qualifications or courses
- A summary of your intercalated degree or postgraduate thesis (if you have done one)
- Any grants you have won.

Management

- Brief description of your audit experience
- Overview of your other management experience, including:
  - Rota management
  - Service development or service improvement including conducting audits and implementing changes thereafter
  - Experience of writing or updating guidelines and protocols
  - Sitting on committees, e.g. risk management
  - Acting as representative, e.g. junior doctors committee
  - Handling complaints (for more senior candidates)
  - Organising events, including induction programmes for junior doctors or nurses, departmental or regional teaching programmes, mock exams, conferences, etc.
  - Dealing with underperforming colleagues (for more senior candidates, e.g. ST3)
  - Any other management experience linked to a personal achievement or outside medicine.

Personal

- Overview of your personal strengths/interpersonal skills
- Basic information about your social life (e.g. hobbies).

Example of an effective answer

"My name is John. I am currently training as an FY2 doctor in the East of England LETB. I graduated in 2011 from Cambridge University. I have trained in the Eastern region for both foundation years, during which I have experienced a range of specialties, including Cardiology, Respiratory, Accident and Emergency, Obstetrics and Gynaecology, and General Practice. Out of all of these, I have particularly enjoyed the medical specialties because of the analytical and communication challenges that they offer and this is the reason that I am applying to Core Medical Training.

During medical school and the ensuing two foundation years, I have gained a lot of confidence in history taking and basic procedures such as cannulation, ABG sampling and urethral catheterisation. Through my cardiology attachment, I gained a good knowledge of ECG interpretation. I was able to perform cardiac catheterisation under supervision, I assisted in the placement of pacing wires and I took the opportunity to observe transoesophageal echocardiography. My A&E attachment helped to increase my confidence in dealing with acutely ill patients; it also provided me with excellent training in how to remain calm and organised under pressure, which has proved extremely useful during my on-call work.

As well as developing good clinical skills, I have sought to develop my teaching skills. I have been involved in teaching undergraduates on basic clinical matters and procedures with both bedside or ward teaching and formal lectures. I have also actively sought to mentor groups of medical students who have rotated through the units I have worked in. Teaching is something that interests me greatly, and which I'd be keen to develop further throughout my training and my career.

Over the past few years, I have also played an active role in audit projects. I have completed two audits, one of which led to a change in clinical practice through the introduction of new departmental guidelines for the follow-up of MI patients. On both audits, I was the lead auditor. As well as this, I have played a key role in organising departmental activities, including a weekly departmental teaching session and some mock vivas for medical students in their final year.

From a more personal perspective, my colleagues see me as someone who is reliable and very supportive. Outside of work, I enjoy team sports such as football and cricket, which give me an outlet to de-stress. I also enjoy reading and spending time out with friends."

This answer takes about 2 minutes to deliver at a realistic enthusiastic pace. Slower candidates (and speaking slowly is by no means a disadvantage) could easily deliver an answer of this length in 2½ minutes.

Why this answer works

- It is well structured. You will have recognised that it follows the CAMP structure. The short introduction where the doctor gives his name and his current post is very effective. Obviously, they should already know your name, but the purpose of this sentence is not to provide information. It is designed to build a rapport. They won't know you at all; so it is nice to introduce yourself.

- The candidate does not just list information or make bold statements about having experience. It is easy to make statements such as "I have gained a lot of audit and teaching experience", hoping that interviewers might understand what was meant by it. Instead, the candidate provides concrete examples of achievements.

- The candidate ends his answer with a more personal slant. Note the use of feedback: "my colleagues see me as someone who is reliable and very supportive." With such a sentence, there is an immediate picture of someone who works well in a team, even though they have never actually said "I am a good team player".

- The information has opened up several avenues of interest that the interviewers can then follow with questions. The information is accurate and punchy: just enough of an appetiser for the panel to gain a feeling of confidence about the candidate.

Ending the answer

In this example, the candidate finished with the personal section. His tone of voice should clearly indicate that he has finished the answer. Another possible finish would involve taking out the sentence: "Out of all of these, I have particularly enjoyed the medical specialties because of the analytical and communication challenges that they offer and this is the reason that I am applying to Core Medical Training" from the first paragraph, and to position it instead in the last paragraph in a slightly modified format:

> "Out of all my attachments and training opportunities so far, I have enjoyed the medical specialties most because of the analytical and communication challenges that they offer; and this is the reason that I am applying to Core Medical Training."

6.2 Why do you want to train in this specialty?

What the interviewers are looking for

This question is testing your motivation for the post and the interviewers will be looking for the following:

- A range of reasons: some marking schemes take into account the number of reasons listed. To ensure that you maximise your score, you will need to state at least three, preferably four. Any more than four and you run the risk of spreading your answer too thin or repeating yourself. You should also ensure that your reasons are sufficiently different from one another so that you do not sound repetitive and the answer has enough variety to keep the interviewers interested throughout.

- Strong explanations, with a personal slant: simply listing your reasons for choosing the specialty will not be sufficient. You need to explain why these reasons are important to you and how you developed your interest.

- Evidence that demonstrates your interest in the specialty: thinking that a specialty will suit you is not enough. The interviewers will be looking for evidence that you have taken steps to test your interest or to gain experience in that specialty. These posts are precious opportunities and your panel wants to know that you are going to make good use of the opportunity if it is given to you.

- Career focus: your choice of specialty needs to come across as something that you have thought about and fits within a career plan. The interviewers will not be keen on recruiting someone who

wants to join the specialty because “it sounds quite interesting” or because they could not get into anything else.

- Enthusiasm: it is not a competition about who will have the best reason or the most reasons; it is about recruiting those who believe in their future in the specialty. This can only be achieved by talking, in some detail, about what you enjoy. Some of the enthusiasm will be conveyed through your description of your experience to date; but most of it will come from your tone of voice and the enthusiastic manner with which you deliver your answer.

Defining your reasons for training in the specialty

Statements such as “I want to train in this specialty because I find it interesting, stimulating, fascinating, enriching, etc.” are common and not particularly informative. Adjectives such as “interesting” and “fascinating” may sound good on the surface, but they are meaningless unless you explain why you find the specialty interesting or fascinating. Use such words sparingly, particularly as most of your competitors will overuse them and the interviewers will be bored of hearing them time after time.

Your answer should be structured around three or four clear reasons. These reasons will of course depend on your personal circumstances and the specialty. For this question, you can also use the CAMP structure as a useful tool to ensure that you cover all angles. Here are a few examples that you can use as a starting point:

Clinical reasons
- The technological aspect (e.g. surgery, radiology, pathology)
- The variety of work that the specialty offers, for example:
  - You deal with different specialties (e.g. Paediatrics)
  - Good mix of medicine and surgery (e.g. Ophthalmology, Obstetrics & Gynaecology)
  - A mix of ward work and clinics (most medical specialties)
  - A mix of chronic and acute patients
  - Involves prevention as well as treatment
  - Mix of interventional and other activities (e.g. Cardiology, Radiology)
  - Opportunity to work in different settings (e.g. community and hospital for Psychiatry, Paediatrics, GUM)
- You get immediate results from your work (e.g. most surgical specialties). Be careful with this reason because surgeons also deal with chronic patients. A better reason may be that you enjoy the combination of the two.
- A strong investigative component, or, on the other hand, there aren’t many investigations available so it offers you a challenge.
- The diagnosis is easy to establish, or on the contrary it is challenging.
- The holistic/psychosocial approach (e.g. Psychiatry, Oncology).

Academic reasons (research, teaching)
- Fast advancing specialty, with a real challenge in keeping up to date and constantly learning new skills (e.g. most surgical specialties, Oncology)
- Good opportunities for research
- Good opportunities for teaching
- Great variety in teaching styles (e.g. simulation in Anaesthetics)
- Opportunity to develop a special interest.

Management Reasons (responsibility, working with others)
- Opportunities to get involved rapidly in areas of responsibility where one has greater autonomy (e.g. Psychiatry)
- Strong multidisciplinary focus (e.g. Psychiatry, Paediatrics, Oncology)
- Mix of independent work and teamwork
- Opportunities to develop services and make a real difference to service provision
- Prefer to work in small teams and therefore hold greater responsibilities (e.g. Dermatology, Haematology, Urology)

Personal reasons (personality, soft skills, social)
- Offers a communication challenge (e.g. Paediatrics, Psychiatry)

- The challenge of dealing with difficult patients and sensitive situations (e.g. Paediatrics, Psychiatry, Obstetrics & Gynaecology)
- Your input has a strong influence on patient satisfaction: makes a big difference to the patient's lifestyle and mobility (e.g. Ophthalmology, Orthopaedics) and therefore leads to greater satisfaction
- The buzz of working under pressure (e.g. surgery, emergency medicine)
- Enjoy working in an environment where detail matters (e.g. Radiology, Pathology)
- Prefer to work in larger teams to learn from a greater variety of people and develop in a more sociable environment.

The CAMP structure is useful to help you think about a wide range of reasons and gives you a natural structure. You can use it as you see fit in relation to your own situation.

You do not have to find one reason in each category; for example, it would be perfectly fine to have two clinical reasons and one management reason; or one clinical reason, one management reason and one personal reason. What matters is that you can present suitable variety in a structured manner.

It is crucial that you remain true to yourself if you want to appear enthusiastic. Not everyone wants to join a specific specialty for academic reasons, so don't force yourself to talk about academic reasons if they do not represent your true motivations. You will only invite further questions which will make you regret having mentioned it in the first place.

Example of an ineffective answer

"I have acquired all the skills to do well in Obstetrics & Gynaecology and I feel that I have a lot to offer the specialty. I also want to train in Obstetrics & Gynaecology because I think it is an interesting and challenging specialty. I like the surgery, I enjoy caring for women and I think that there is no better job than to help a baby enter life."

Why this answer does not work well

This answer is ineffective for several reasons:

- It consists mostly of a list of reasons, with no real attempt to substantiate them. None of the reasons have been developed in any depth. In particular, the use of words such as "interesting" and "challenging" without an explanation of why the specialty is so attractive makes the answer particularly vacuous. Also, what does the candidate mean by "I enjoy caring for women"? What does he/she enjoy about it?

- The candidate does not attempt to link his/her explanations to their experience or personal story. When delivered orally, the answer will sound unenthusiastic and bland. There is a need for more depth, which would in turn translate into a more dynamic answer.

- One of the reasons that the candidate presents is that he/she has the skills for the specialty. The main problem is that we all have skills that would make us suitable for jobs that we don't particularly want to do. Having the skills is therefore not a sign of motivation. These skills may be something worth mentioning in the answer, but only as a conclusion and providing the candidate explains, even if briefly, what these skills are.

On the positive side, there is an attempt to choose a range of reasons which are of a different nature, e.g. a technical reason (liking the surgery), a patient-based reason (enjoying caring for women) and personal satisfaction.

Example of an effective answer

"Obstetrics & Gynaecology is a specialty in which I have developed an interest since my first attachment in Obstetrics at medical school; and which I have learnt to discover and enjoy further during my Foundation Years attachments.

One aspect of the specialty that I have particularly enjoyed is the variety it offers. You can experience extreme joys – for example when helping to deliver babies – but you also have opportunities to help patients through particularly difficult times – for example when dealing with miscarriages or cancers. I personally experienced these highs and lows when I helped an HIV-positive woman safely deliver a healthy baby, whilst the very next day having to console a patient who had just been told that she would need to have an operation that could result in subfertility. I feel very enthusiastic at the prospect of being able to make a difference to women in situations which evoke such extremes of emotions, high or low.

I like the fact that Obstetrics & Gynaecology is a very procedure-based specialty complemented by a challenging medical side. During my attachments, I enjoyed performing examinations and observing procedures such as hysteroscopies, diagnostic laparoscopies and open surgery. I have always thoroughly enjoyed both surgery and medicine, and I feel that a career in Obstetrics & Gynaecology would enable me to develop both interests.

From a personal perspective, I find the holistic approach that Obstetrics & Gynaecology offers very rewarding. Having attended sexual health clinics and women's health clinics both as a medical student and as a junior doctor has really helped me appreciate how much difference we can make in addition to the purely physical needs of the patient. This makes Obstetrics & Gynaecology a well-rounded specialty.

Finally, I feel that the specialty offers a wonderful opportunity to work closely with other members of a team. I have particularly enjoyed the buzz of working on labour wards with midwives and the challenge of ensuring good communication and team working to ensure the safety of our patients, despite the sometimes fast-moving conditions and the possible conflicts that can develop as a result of shared responsibilities."

This answer can be delivered in just over 1½ minutes at normal pace, which should reassure you that a three-point personalised approach works well.

Beware of criticising other specialties

Candidates commonly criticise other training schemes (e.g. explain that they chose medicine because they found surgery too boring or surgery because they found that medicine does not achieve fast results). This would give answers along the lines of: "I feel that surgery can be very samey and that there is no real opportunity for prolonged contact with patients after the follow-up. Medicine, on the other hand, is much more varied and does offer better opportunities for continuity of care."

You can see how inflammatory such an answer could be. And even if the interviewers agree with the candidate, it will no doubt present him/her as someone who is negative. The answer does not sell the candidate's love for medicine in a positive manner. In particular, the lack of examples makes the candidate appear judgemental.

Generally, I would advise against selling your interest for one specialty by putting another one down. You must make sure that you present a positive image. The only exception to this would be if you have changed career path, in which case you could explain your interest in the specialty by comparing it to your previous specialty. If you do this, make sure that you sell the positive points of your previous specialty. When mentioning the negative aspects, present them as something that you did not enjoy rather than generalising with sentences like "Specialty X is not very interesting because …"

The best format to explain a switch of specialty would be to explain:

- What you enjoyed about your previous
- Why you felt limited within it
- Why this new specialty is the answer to your problems.

Selling your enthusiasm for a Core Training post

Those who are applying to named specialties (e.g. Ophthalmology, Cardiology, O&G, Paediatrics, Anaesthetics, Urology, ENT, etc.) should find it easier to explain their career choice than those applying to Core Training posts. Indeed, those applying to Core Training schemes in medicine, surgery or acute care are not actually applying for a specific specialty and may therefore lack focus in their answer. Specialties within medicine or surgery can be very different from one another and this leads to some candidates sounding vague and seemingly unmotivated.

There are, however, aspects which are common to all or most specialties within medicine, surgery or acute care. Here are a few to get you started:

Medicine
- Excellent problem-solving environment
- Opportunity to deal with psychosocial issues as well as physical
- Good mix of ward and clinic work
- Opportunity to follow up patients with chronic illnesses
- Enjoy contact with patients
- A lot rests on your communication skills
- Enjoy the varied teamwork.

Surgery
- Enjoy manual/technical skills and challenges
- Enjoy the satisfaction of making an immediate difference to patients
- Good mix of acute and chronic patients
- Enjoy the fact that it is very evidence-based and fast moving
- Look forward to research opportunities
- Enjoy working under pressure.

Acute Care
- Enjoy working under pressure
- Enjoy the challenge of dealing with the unexpected
- Strong communication challenge too in terms of reassuring patients and relatives, and managing expectations
- Good teamwork angle, particularly in dealing with other specialists.

You can of course add your own reasons based on your own experience of the field to which you are applying. By following a similar pattern to the answer given earlier, and, more importantly, by using your own experience, you will be able to create a strong answer.

If you already have an idea of the specialty that you want to do once you have completed your Core Training rotation, then I would suggest that you use it in your answer too. However, be careful to only bring it up at the end of the answer (i.e. your third paragraph). If you go on about one single specialty throughout the whole answer, you will cause three problems:

- The consultants interviewing you will often be from a different specialty and they will be looking for some balance (you wouldn't want to bruise their egos too much…).

- You will give the feeling that you may be bored during the Core Training rotation whenever you are not working in your chosen specialty. This could be problematic if your two-year rotation only contains 4 months in that specialty (if anything).

- By spending the whole answer on one specialty, you may face a secondary question of the type: "What will you do if you don't get into Cardiology in two years' time?"

By spending two paragraphs talking about medicine, surgery or acute care generally and by focusing on your chosen specialty in the final paragraph, you will establish a sensible balance in your answer. This will show that you are motivated for the whole programme but that you also have a clear focus.

Better still, you could identify two specialties which are of a similar nature. For example, Cardiology and Gastroenterology both have a diagnostic and a procedural side. In that way, you do not show too strong a focus on one specialty but you retain your focus in the answer. By mentioning two specialties rather than one, you also present yourself as someone who is open-minded.

So, your third paragraph could be follows:

"Finally, the two specialties that I have particularly enjoyed over the past 3 years have been Cardiology and Gastroenterology because they provide a good mix of pure medicine, including diagnosis and management, and of procedures (for example, pacemaker implantation and endoscopies). Core Medical Training would help me find out more about both specialties so that I can make the right choice."

6.3 Why do you want to train in this region/LETB?

We all know that the real answer to this question is either "Because that's where I live" or "Because that's where there are jobs!" However, the marks for these are likely to be minimal.

What the interviewers are looking for

The marking for this question is fairly consistent across all LETBs. All LETBs will be looking for candidates who are motivated for the training that they offer and will expect you to have developed a good understanding of their training programme (i.e. it is not enough to state geographical reasons for wanting to work or train in a particular region). As well as good reasons, the interviewers will expect good and clear explanations of your motivation. Here is an example of a marking schedule:

0	No clear reason
1	Vague geographical reasons, but no reasons relating to the training programme
2	Limited understanding of the training programme with unclear reasons
3	Reasonable to good understanding of the training programme with clearer reasons
4	Excellent understanding of the training programme. Clear and detailed explanations of the reasons

As you can see, the marking structure leaves some room for subjective judgement but one thing is clear: you should do some homework about the LETB to identify what the training scheme offers; otherwise you will struggle to score more than 2.

For most LETBs, you should be able to score at least 3 by spending a minimum of time reading relevant internet sites or talking to people who are already training there. With a bit more homework and a clear structure, you could easily score the maximum mark. Clearly, this is a question to expect and this simple preparation makes it easy to score well.

What reasons can you mention?

Here again you can use the CAMP structure to help brainstorm for reasons and structure the answer appropriately.

Clinical reasons (including clinical practice and clinical training)

- The area covers a varied population (e.g. ranging from deprived to affluent populations, multiethnic or otherwise), thus providing a good case mix for training.
- The region covers types of patients that are of particular interest to the specialty applied for (e.g. a primarily elderly population, a strong refugee population, strong diabetes prevalence, etc.).

- The rotation provides training in a mix of different settings (e.g. good exposure to both DGH and tertiary centres, or community settings for some specialties) or, on the contrary, it has more DGH or tertiary exposure (depending on what your future plans are).
- Some of the hospitals are renowned centres for the specialty to which you are applying, thus allowing you better exposure to your future specialty of choice, or special interest that you are interested in developing.
- The LETB provides good support for taking and passing exams, with established structured programmes.
- The LETB encourages and provides support for trainees to pass specialty-specific exams early, which may not be compulsory (a sign that the training programme is attempting to stretch its trainees, which would suit the more ambitious candidates).
- The LETB has achieved high pass rates at Royal College exams, which reflects the quality of support received.

Academic reasons
- The training programme actively encourages an involvement in research.
- You are interested in research and the LETB contains centres which would enable you to further that interest.
- You may already have developed research projects in this region and wish to continue training in the same region to complete or pursue these projects further.
- You have an interest in teaching and will be primarily training in teaching hospitals, thus giving you opportunities to get involved.
- Local medical schools employ teaching methods which match your interest and experience, and with which you will have opportunities to become involved.
- Teaching qualifications are encouraged for those interested.
- The LETB runs good courses for research and teaching.

Management reasons
- The LETB encourages active participation in audit.
- The LETB provides structured management training (e.g. running in-house courses).
- There are opportunities to take on responsibilities (e.g. clinical governance, service development).

Personal reasons
- You have worked/trained in the region before and enjoyed your time there (you should be able to explain what you enjoyed).
- Your wife, husband or partner works in the region.
- Your family, relatives and/or friends are close by, thus providing a good support network.
- You have responsibilities which would warrant working in that region. This could include caring for relatives, social responsibilities, responsibilities with local charities or other associations.
- You enjoy the region.
- You have hobbies or personal interests that would be best maintained in that region.

These are just a few of the reasons that you can discuss and should give you a starting point to think about your own.

One question, which I am often asked, is whether it is acceptable to bring social reasons into the answer. Those who ask are concerned that they may be projecting the wrong image. The answer to this question is that it is acceptable because the right social circumstances are likely to make you a better and more stable trainee. However, you should ensure that social reasons are mentioned at the end of the answer, after you have successfully demonstrated your knowledge of the training programme.

Example of an ineffective answer

"I want to work in the East of England because of the variety of population and the different experiences that I can gain there. It is also close to London where most of my family and friends are based, whilst also providing access to the countryside."

What makes the answer ineffective?

Although the candidate alludes to the variety that the LETB offers, it is not very clear as to what that variety is and why this is relevant to the candidate's training. The answer could be given in just about every LETB in almost every specialty, and it is clear that the candidate has made no effort to research the training scheme that he/she is applying for and to describe why that training scheme is of particular interest. This answer would probably score 1 mark only because it has a strong focus on the geography and personal reasons, but not much else.

Example of an effective answer

"I feel that East of England is an ideal region for Cardiology training, for many reasons.

First of all, it offers a huge variety in terms of settings. There is a good selection of smaller hospitals such as Kings Lynn, Hinchingbrooke and Bury St Edmonds, larger centres such as Addenbrooke's and Norwich, but also specialist tertiary centres such as Papworth. The East of England also covers a vast area, encompassing rural and urban areas from Norwich to Bedford, as well as middle-class and deprived populations. This makes the training scheme very broad-ranging and provides a good opportunity to get involved in all clinical aspects of Cardiology.

I also know from my background reading that many of the hospitals are investing a lot of resources into cardiac services, for example through the creation or increase in capacity of catheter labs in Kings Lynn, Ipswich and Cambridge, some of which will be mobile. This obviously increases opportunities to gain hands-on experience in interventional cardiology (one of my areas of interest) but also demonstrates that the region is forward thinking in its approach, which makes it an exciting environment in which to train.

One of the area's great assets, in my opinion, is also that it contains major teaching hospitals such as Addenbrooke's and Norfolk and Norwich Hospital. The proximity to one of the oldest and one of the newest medical schools provides a unique opportunity for me to become involved in a wide range of teaching activities and to develop new skills, both in traditional teaching methods and in newer ones such as problem-based learning. Working near major centres such as Cambridge and Papworth also makes it an ideal environment to develop research interests.

Finally, so far I have trained mostly in the London area and I am very keen to discover a new environment. The East of England provides a nice semi-rural setting whilst at the same time having the advantage of remaining within easy reach of London, where I have a lot of friends and family.

Overall, I feel that it will provide me with an excellent training in a dynamic environment, both clinically and academically, and will give me many opportunities to develop a strong portfolio which will enable me to give back fully to the specialty once I become a consultant."

This answer can be delivered in approximately 2 minutes. It clearly sets out different reasons in each paragraph, all of which are properly signposted. The candidate has covered several domains including clinical, academic and personal reasons.
The level of detail within each paragraph is just enough to demonstrate that the candidate has seriously considered his reasons and has taken the trouble to do some homework, which is by itself a sign of motivation. More importantly, for each reason, the candidate has demonstrated why it mattered to him. For example, saying that the region was setting up new catheter labs is not interesting by itself until the candidate explains that it will give him an opportunity to gain hands-on experience in interventional cardiology, which is one of his areas of interest. In your answers, make sure that you do not limit yourself to stating a list of reasons; you should explain their relevance to your application.

Finally, the social reasons are highlighted too – though not until the end – to round off the answer and give a more personal dimension.

6.4 How would you describe your communication skills?

What is communication and what are they looking for?

The interviewers will be looking for an answer which is mature, relevant to the specialty that you are applying for and backed up with personal examples. To score highly, you must present different facets of your communication skills, demonstrate their relevance to the specialty and provide suitable examples.

Communication is an integral part of your daily working life and is the cement that ensures that you maintain good relationships and that you are effective in your work. In the course of your work, you generally demonstrate the following communication skills:

Active listening and empathy

Active listening and empathy are ways of letting the other person know that you understand their feelings, that you care about what they are saying and that you are non-judgemental.

In your dealings with others, this will translate into the following behaviours:
- Knowing when to keep silent and let the other person speak
- Not interrupting
- Being attentive to what the other person is saying and showing it (open posture, appropriate nodding and good eye contact)
- Probing in a supportive manner and using open questions
- Showing support, warmth, care and attention
- Being sensitive to the emotions of others.

You can demonstrate such behaviours in the following situations:
- Breaking bad news
- Talking to an upset patient, relative or colleague
- Dealing with an angry person (patient or colleague)
- Handling complaints
- Dealing with a conflict
- Discussing problems with colleagues (work-related or personal).

As a result, you will achieve the following:
- Gain cooperation from the other person
- Build trust and develop a rapport
- Make people feel more confident
- Encourage discussion and greater openness.

Conveying information in a clear and structured manner

As a doctor, you need to convey your message in a manner that suits your audience. In practice, this will include the following behaviours:
- Anticipating the needs of your audience
- Using clear and unambiguous language, with appropriate jargon
- Choosing the most appropriate communication method, e.g. written, face-to-face, telephone, email, models, diagrams, leaflets
- Adapting your communication to the understanding of your audience.

You can demonstrate such behaviours in the following situations:
- Explaining procedures or management plans to patients
- Seeking consent
- Writing discharge summaries, reports or notes
- Presenting a patient to a senior colleague with a view to gaining advice
- Teaching colleagues
- Presenting at a meeting

- Educating a patient about a chronic condition, or writing leaflets.

As a result, you will achieve the following:
- Better cooperation and appropriate response from the other person
- Time efficiency
- Fewer mistakes/errors.

Influencing and negotiating skills

During the course of your daily work, you will be confronted by difficult situations, disagreements, or even conflicts. To resolve them, you will need to influence other people (i.e. make sure that they do what you want them to do without coercing them or manipulating them, which could aggravate the situation and build resentment).

You will also need to negotiate. In your dealings with others, this will translate into the following behaviours:
- Understanding the impact of your communication on others and adapting your approach accordingly
- Confidently but non-aggressively setting out and defending your point of view
- Being tactful and diplomatic
- Being encouraging and constructive when talking to others.

You can demonstrate such behaviours in the following situations:
- Dealing with a difficult colleague (e.g. not pulling his/her weight)
- Dealing with difficult patients or complaints
- Conflicts with nurses/midwives or any other colleague
- Conflict within an MDT environment due to different personal agendas
- Negotiating the admission of a patient onto a different ward (e.g. if doing general on-calls) or into ITU
- Designing rotas
- Negotiating study or annual leave.

As a result, you will achieve:
- Outcomes that match your expectations
- Better working relationships and understanding of your colleagues.

Answering the question

To produce an effective answer, you need to reflect on your day-to-day experiences and determine in which context you have used the above skills. You only need to discuss a small number of points but it is important that these points are backed up by your personal experience. The answer must be *your* answer and not some standard explanation of what constitutes communication skills.

Blow your own trumpet. At an interview, you must sell yourself positively; it would make no sense to play down your communication skills. Even if you think that you are not that good, you need to find the courage to state that you are; if you don't sell yourself, the interviewers won't be doing it for you!

Phrases to avoid:
- "My communication skills are above average" (not very positive)
- "My communication skills are okay" (meaningless and uninspiring)
- "My communication skills could be improved" (are they bad?)
- "I would give myself 8 out of 10 (meaningless; why not 9 or 10?)
- "I think that I have good communication skills", if delivered in a sceptical voice (if delivered confidently, it could be okay)
- "My communication skills are excellent" (don't overdo it!)
- "My English could be improved" (They will be testing your English at the interview. No need to shoot yourself in the foot by reminding them of a potential weakness)
- "I am a good communicator because I can speak 5 languages" (the fact that you can speak several languages doesn't mean that you can communicate; there are plenty of people who speak English perfectly and are not good communicators. Of more relevance will be your ability to relate

to people at different levels, including those from other cultures or ethnic backgrounds. Languages are only tools that help you achieve this).

Good phrases to use:

- "I have good communication skills"
- "My communication skills are very good"
- "I have developed good communication skills" (this recognises that communication is an evolving skill)
- "I have effective communication skills" (meaning that they are achieving results – it saves you having to say that you are good)
- "I have received very positive feedback on my communication skills, not only from nurses and other colleagues, but also from patients" (Remember: feedback is a good way to introduce objectivity in your answers).

Many candidates feel uneasy saying that they are good. This unease comes from the tendency to limit their answer to a single statement of the type "I feel that I have good communication skills" which, if not backed up by concrete examples, will sound very boastful and arrogant. Your answers can sound genuine only if you mention practical examples; by being down to earth and practical, you will reach your comfort zone, which in turn will make you feel more confident in your delivery. Mentioning feedback received will also help make your answers more realistic and will make you sound and feel more confident.

Example of an ineffective answer (commonly given)

"I think that my communications skills are okay but obviously can be improved. Communication is particularly important in my specialty because we have to discuss complex issues with patients and be able to talk to them in a way they understand. We also have to break bad news and deal with difficult patients. I can speak several languages including English, Hindu and Tamil, which can be extremely useful in the region where I work, and I have also done a lot of teaching, which is also important in the specialty."

On the positive side, the candidate has attempted to discuss a variety of communication issues. However, this answer is ineffective because:

- The candidate focuses on tasks (breaking bad news, teaching) and not on skills so much: the skills which enable him/her to carry out these tasks effectively (e.g. empathy, listening, etc.).
- The answer discusses the importance of communication more than the candidate's abilities to communicate.
- The candidate does not sell him/herself (e.g. "okay").
- The candidate uses words which are detached (e.g. "in my specialty"). If you are applying to a given specialty, then why not mention its name? Stating "Communication is particularly important in Ophthalmology" (say) would be more effective. Similarly, if you come from abroad, do not say "In my country", but "In India", or "In Poland, where I first trained". It makes the answer more personal and more direct.
- Listing English as a language is not relevant. As for the other languages, they do not indicate that the candidate can communicate; merely that he has tools to perhaps relate to patients from certain ethnicities. The link between the languages and how they demonstrate a good ability to communicate should be made more explicit.

- Stating that the skills "obviously can be improved" is a reasonable statement to make; however, mentioned in this manner, it suggests that the candidate is not very good at communication. Instead, the candidate should convey a more positive message by mentioning that he/she is constantly finding opportunities to develop his/her communication skills further (for example, by attending courses such as a recent teaching course). This would create a more positive feeling.

Example of an effective answer

"Throughout my training I have developed effective communication skills across a wide range of areas. One of my main strengths is my ability to relate to others and empathise with them. During my diabetes attachment, I often dealt with patients who felt very apprehensive and at times overwhelmed by their diagnosis, its potential complications and implications. I found I could easily engage with them at a level where they felt comfortable expressing their thoughts and feelings. I can remember a couple of patients who had been particularly affected because of the impact of diabetes on their lifestyle, and who commented later that they felt I had given them the time they needed to deal with the issues that mattered to them. They felt that my communication approach helped them to open up.

As well as this, I feel comfortable expressing my opinions clearly in the different areas of work. I take great care to prepare well to ensure that I don't miss any important points and I take account of what other people want to know and of what they will be doing with the information. For instance, on a ward round, I ensure that I focus on the salient points and leave aside the unimportant details. When discussing a diagnosis or treatment plan with a patient, I ensure that I take account of their prior knowledge. I can then convey information that I feel will matter to them.

Over the course of my training so far, I have developed good negotiation and influencing skills. Experience has taught me how everyone in a working system has their own priorities, pressures and even agendas. I feel that, as I have developed an increased clinical understanding, I have improved my ability to prioritise my patients' needs against those of colleagues. This means that I am better able to judge whether to push for something in the interest of my patient or, perhaps, having listened to my colleague, allow them to take priority - for example, when ITU are reluctant to admit a patient or when a radiologist is refusing to perform a scan. I have also learnt to appreciate that not all colleagues respond in the same way even if I try to maintain the same approach, tone and language when dealing with them. One of the lessons that I have learnt as a junior doctor is the importance of remaining calm when dealing with someone who disagrees with you and to try to see things from their point of view. By telling myself that their refusal is nothing personal and by trying to understand their agenda, I have found that I could have very constructive discussions which often led to positive outcomes. In my training in respiratory medicine, this will come in particularly handy."

6.5 Give an example of a situation where you showed empathy towards a patient

What situations can you describe?

A good example would be a situation where a patient wanted to take a course of action which you felt was obviously against their best interests. This could include:

- A patient who wanted to self-discharge against medical advice
- A patient who was scared of surgery or a procedure
- A patient who refused to comply with their treatment, condemning themselves to a poor outcome
- A patient who refused to involve relatives but who required strong social and moral support.

Whatever example you choose to describe, you must ensure that it is *your* communication skills that made a difference. You must also ensure that you are not seen to coerce the patient into making a decision.

Answering the question

Since this is a question asking for a specific example, you should use the STAR technique.

Example of an effective answer

Situation/Task "Whilst working in Accident and Emergency I saw a young Asian woman who was 6 months pregnant. She was very timid but also appeared to be quite distressed and I felt that she would need some support

Action	To ensure that she had some privacy and felt more at ease, I took her to a cubicle where we could talk more easily. I took my time, made sure that I did not rush her and started to take a history. I could see that she was becoming a little tearful and so used a softer tone of voice. I could see from her composure and her body language that she wanted to tell me more but was somehow reluctant to do so. I felt it was important to let her talk to me in her own time and I gently asked about why she was so upset, reassuring her that it was okay to discuss her feelings. This prompted a sudden release of her emotions, and she started to cry. I gave her some more time to compose herself, making sure that I remained silent in order not to overburden her with words. After a few minutes of silence, she explained that she had miscarried twice before and that her husband and his family thought she was an unfit wife. I felt that she was relieved to confide in someone.
Result /Reflect	Once she had opened up we spent some time discussing how she was handling the bottling up of her emotions and I offered her the possibility to see a counsellor if she felt she needed one. Her medical complaint turned out to be minor and with the good rapport we had built she trusted the diagnosis. Overall I found that by listening actively, preparing the scene and mirroring her pace I was able to engage with the patient quickly. Using words that were non-threatening and from her own vocabulary also helped greatly."

This story describes in some detail how the doctor approached the patient and how he made a difference. In this example there are further opportunities to demonstrate empathy by discussing how the doctor then handled the patient once she had admitted what the problem was, but this would make the answer far too long and it may be best to wait to be prompted for more information. Note the reflective paragraph at the end where the candidate states what he/she did well.

6.6 Describe a time when you had to defend your own beliefs regarding the treatment of a patient

What the question is testing and what the interviewers are looking for

The interviewers will be looking for a range of skills including:

- Your ability to listen and take on board criticism without losing your cool
- Your ability to set out your opinions in a constructive manner
- Your ability to influence others in a non-threatening manner.

Scenarios you can discuss

Hopefully this is not a situation that recurs much in your daily working life, so any situation where this has occurred should stand out in your mind. This could be for example:

- A situation where you made a decision that was queried by one of your peers, or seniors or a nurse, and where you had to defend your views
- A situation where your decision or belief with regard to treatment was queried either by the patient or one of his/her relatives
- A case review meeting where you were asked to justify your actions.

How would you normally seek to convince someone that you are right?

- Firstly, you would ensure that you have all the information to hand to be able to present a sensible case.

- Secondly, you would present logical arguments to the other person and would wait for their reaction. You would then pay attention to what they have to say, giving them the opportunity to ex-

press their opinion freely without interruption. It will make them feel valued and, you never know, they may have a valid point.

- Thirdly, if your first approach did not work, you may want to try a different approach. In some cases, the alternative approach may be to involve a senior colleague in the debate to give more authority to your argument.

- If none of this works then there may not be an easy conclusion to the problem. If patients are involved, the complaint procedure may need to be invoked or even court action, etc. For the purpose of answering this question you should ensure that you choose an example where you were successful at defending your beliefs otherwise you will run into trouble, however justified your actions were.

Example of an effective answer

Situation/Task	"I had admitted a patient for diabetic ketoacidosis who, I felt, required a high dose of insulin. I asked a staff nurse to administer the treatment, which she refused to do since this was a high dose, beyond that normally given, and she would only give a lower dose.
Action	I spent a couple of minutes explaining patiently and in a normal tone of voice to the nurse, that as well as the patient's blood sugar we needed to deal with the metabolic acidosis, which requires a higher dose of insulin. As she refused to go ahead and, in view of the urgency of the situation, I administered the treatment myself in order to ensure the patient was safe at all times. Once the patient was stabilised, I asked the nurse if she wanted to discuss the matter in a more relaxed setting. We went to the mess and I asked her to tell me how she saw the situation. She explained that she had never come across a situation like this in her experience and did not feel comfortable giving a potentially dangerous treatment without understanding why. With her agreement I spent some time explaining the pathophysiology of diabetic ketoacidosis and why a high dose was necessary. I made sure that I kept to terms that she was happy with and throughout our conversation asked her questions to check that I was communicating clearly. I also explained to her in a non-judgemental manner how her actions may have endangered the patient, emphasising that this should in no way stop her from raising her concerns if she felt she needed to in future. Although her behaviour had potentially threatened a patient's health, I wanted to make sure that she used this mistake as a learning point and that we continued to have a good working relationship. To that end, whilst suitably conveying my concerns to her, I made sure that I did not give her a guilt trip.
Result/Reflect	The nurse felt that she understood the situation better and apologised for her action. This incident enabled us to have a closer relationship and, as a result, enhanced the standard of care that we were able to provide to all future patients."

Note the emphasis on the communication aspect of the scenario about listening, being non-judgemental but also assertive. Also note that there is some clinical content; however, it has been reduced to what is strictly necessary to understand the context and the actions of the individuals involved.

Don't be afraid to go into some detail. Detail and facts will help build up your credibility and will make the example look real. But always make sure that those details are relevant to the question being asked.

You can use the "Result/Reflect" section to explain a little bit more than what happened at the end of the story, by adding a sentence about how it helped you become a better doctor. In this example, it is about building bridges with the nurse and enhancing the working relationship. It helps add depth to the answer.

6.7 Describe a time when your communication skills made a difference to the outcome of patient care

What examples can you use?

The question focuses not just on your communication skills, but on a situation where they actually made a difference to the care of a patient. There are a number of areas that you can explore:

- Situations where the patient was reluctant to agree to a procedure because, perhaps, they were scared (maybe due to a previous bad experience) or had trouble understanding what it involved
- Situations where the patient had needs which they had not clearly expressed and which you managed to identify through good communication
- Situations where you communicated well with a range of members of your team, which then led to efficient action towards the care of a patient.

Although the question does not specify whether the communication skills should be directed towards the patient or towards the team, I would recommend that you play safe by addressing communication with the patient (i.e. the first two points) rather than with the team as this is likely to have a greater impact.

Example of an effective answer

Situation/Task	"Whilst working in Accident and Emergency, an elderly lady presented with left ventricular failure. On being told that she would require admission she became very unhappy and refused to be admitted. After her initial emergency care, I spent some time with her in order to ascertain why she was so reluctant to come in and it transpired that her husband, who was disabled as a result of stroke and dementia, was on his own at home and that she did not want to leave him by himself.
Action	I spent some time listening to the patient and trying to show as much empathy as possible so that I could gain her trust. My main aim at that stage was to let her talk so that I could identify how we could compromise with her. I explained to her that we would do our utmost to take care of her husband as well as her, and that one solution would be to involve social services so that her husband would be looked after whilst she was recovering. At first she was reluctant to involve social services because she felt that her husband may be taken away from her. I was able to reassure her that this would not be the case and that her husband would be well looked after.
Result:	The patient was happy with this solution and subsequently accepted to be admitted.
Reflect:	I felt that I was able to make a real difference by showing real empathy towards the patient at a difficult time for her, and by looking at the situation as a whole rather than concentrating solely on her physical needs."

This example is effective because the story is easy to follow. The context is set out clearly, as is the action that the candidate took. Note the small amount of clinical information, which is just enough to aid the comprehension of the scenario without overwhelming the interviewer with unnecessary detail that would distract from the candidate's communication skills.

The final paragraph summarises the main points that the candidate wishes the interviewers to take on board, effectively highlighting how the example given actually answers the question.

6.8 What makes you a good team player?

Before you can answer this question, you must understand what being a team player means. Most candidates are able to quote a few of the attributes of a good team player (the most popular one being that a team player understands his role in the team) but they are unable to explain what they mean in practice. This then makes it difficult to provide meaningful examples.

The following table sets out and develops the key attributes of a good team player. It will help you crystallise your thoughts and come up with your own ideas and examples:

Qualities of a good team player

Understands their role in the team and how it fits within the whole picture
A good team player understands what is expected of him/her and is able to anticipate and address the needs of other members of the team. He/she must also understand what is expected of others so he/she can work with them effectively. In practice, he/she:

- Is reliable, i.e. delivers quality results in a timely manner and follows through on his assignments
- Is consistent, i.e. delivers good quality of work all the time and not just when someone is watching him/her.
- Works hard and does his/her fair share of the work. Takes responsibility to prioritise and organise his/her work appropriately to deliver results
- Involves others appropriately, e.g. asking for advice or help, referring specific issues to others who have greater knowledge of the problem
- Takes the initiative and works as a problem solver, i.e. does not simply do what they are told, does not blame others, does not avoid getting involved and does not let others deal with problems alone.
- Shows commitment to the team. Puts the team's success before his/her own pride/success (e.g. if invited to do a non-glamorous task).

Treats others with respect and is supportive and willing to help
A good team player is considerate and courteous towards their colleagues. He/she demonstrates understanding and shows appropriate support towards others to help get the job done. An effective team player deals with other people in a professional manner.

In practice, he/she:
- Is consistently approachable (i.e. not just when it suits them)
- Responds to others' requests for help, even if it can be inconvenient
- Takes the initiative to offer help when he/she feels someone needs it
- Allows others to express their opinions and respects them
- Takes into account other people's agendas and feelings
- Goes beyond their differences with others and finds ways to work together to get the job done
- Shows diplomacy and tact
- Does not gossip maliciously or attempt to undermine others
- Demonstrates a good sense of humour and knows how to interact with others in a more social context.

Is flexible and adaptable and can compromise
A good team player adapts to ever-changing situations without complaining or resisting. In practice, he/she:

- Can consider different points of view and compromise when needed
- Does not hold rigidly to a point of view especially when the team needs to move forward to make a decision or get on with things
- Is able to strike a compromise between holding on to his/her own beliefs and convictions whilst respecting and taking on board others' opinions
- Shows willingness to change working methods to adapt to new circumstances, without complaining, getting stressed or resisting change.

Communicates constructively and listens actively
Communication is the lynchpin of any good team and a good team player encourages and contributes to good communication. In practice, he/she:

- Speaks up and expresses his/her thoughts and ideas clearly, directly, honestly, and with respect for others and for the work of the team
- Proposes ideas that help resolve problems rather than create them
- Absorbs, understands, and considers ideas and points of view from other people without debating and arguing every point
- Avoids interrupting others to force their point through
- Is willing to accept and listen to comments or criticisms from others without reacting defensively, even if they come from more junior colleagues
- Shares appropriate information with colleagues and keeps them up to date about progress on his/her assignments.

Answering the question

It would be tempting to list all the above qualities in one answer. However, it would sound corny. To answer the question effectively, you must pick three or four of the above skills, which you feel characterise you best, and expand on each using your past experiences. Spreading three points over 2 minutes makes it 40 seconds per point, which gives plenty of time for a couple of brief examples.

Example of an effective answer

"One of my key strengths as a team player is definitely my ability to motivate other people when things are not going well and to support them through hard work and by making myself available to help when required. Over the past 4 months, during my attachment in Oncology, I worked with a couple of other junior doctors. One of them was finding it difficult to come to terms with the terminal aspect of some cancers and I tried to spend some time with her to help her see the positive aspects of our job. I also tried to encourage her to seek some advice from senior colleagues and occupational health, which she did.

As a member of the team I work very hard to ensure that I do all my jobs on time and with the quality that my colleagues expect of me. For example, I work hard to ensure that everything is organised and ready for the morning ward round and that all test results are ready to be presented to the Registrar or consultant. Once the ward round is finished I organise the jobs on a spreadsheet and ensure that I order the appropriate investigations early so that the results are back in time to be checked and acted upon within the working day. In some cases, this involves negotiating with the lab or other colleagues for some urgent review and, when that happens, I ensure that they understand I am trying to get things done with good reason and not simply to impose on their service. I have found that, by remaining calm and polite, I am able to get the majority of tasks done. I have learnt the importance of presenting a good clinical case and not simply arguing when someone shows scepticism.

Finally, I have always been very proactive in discussing problems with colleagues so that we can all improve and the team can provide a better service. As an example, recently I felt that the team had started to become a little inefficient and that the standard of note keeping had gone down. This meant that some investigations were either overlooked or patients were seen twice for no reason. I addressed the issue at a team meeting and offered to do an audit, which has now led to a tightening up of our procedures. By presenting the problem as something that concerned us all rather than by placing the blame on some individuals, I managed to engage the team in resolving the issue."

This answer is effective because it focuses on a handful of key points (i.e. it does not simply list 20 attributes of a good team player); each point is clearly backed up with personal experience and presents the candidate as someone who is clearly playing an active role in the team rather than waiting for others to tell him what to do, when to do it and how to do it.

6.9 Give an example of a recent situation where you played an important role in a team

This question is asking for a recent example. Typically, this means the last few months (though you could probably get away with a one-year-old example).

Also, note the focus of the question is on a situation where teamwork is important as opposed to a situation where you were a good team player. However, you should not be fooled by this; it is a question about you and your ability to demonstrate good team-playing abilities. You must therefore find an example where you played a key role.

Examples that you can use

Identify a situation in your recent past where you have had the opportunity to demonstrate a range of team-playing skills set out in the previous question. This could be a situation where you:

- Participated in the organisation of an event or project such as organising a seminar, regular teaching sessions, health camps, awareness programmes, etc.

- Had to deal with a complex patient, where team playing was important. In order to make the answer interesting you would need to find an example where you had to deal with a multidisciplinary team, for example. You could then explain how you participated in the debate about the management and ongoing care of the patient, and how you interacted with all members of the team to achieve a safe discharge.

- Had to deal with an emergency by using the staff resources available, whilst maintaining constant communication with your seniors so that they could have an input into the process and would be fully briefed by the time they arrived. Note that, in order to highlight as many skills as possible, you would need to ensure that the situation was complex enough to show how your role was key to the success of the team. For example, if your seniors are there with you and they are managing the situation themselves (e.g. crash call), you are losing the opportunity to emphasise the communication aspect of your role in keeping them up to date.

Example of an ineffective answer

"I work every day as part of a team, dealing with my immediate colleagues, nurses and other doctors. I am aware of my limitations and seek help when necessary, and I communicate well with everyone in the team. I am willing to help and motivate others."

This answer is too vague and general. In fact, it does little more than summarise the job description. Also, it does not actually answer the question, which is asking for an example of a recent situation, i.e. a specific scenario, in which you were involved.

Another example of an ineffective answer

"I had an elderly patient who wanted to self-discharge because she was worried about her dog. I talked to the nurse and the consultant, and eventually the patient agreed to stay one more day. The patient left the hospital the next day and was happy with the way she had been dealt with."

This answer follows the STAR structure, which is a plus point. It starts well by explaining the context that leads to the team action being started. However, the "Action" section contains very little information:

- Why did the candidate talk to the nurse or the consultant? Probably because the consultant is responsible for the patient and had to be informed. As for the nurse, it might have been because she had a good relationship with the patient and a good understanding of their psychological issues too through the rapport she had built with that patient. This needs to be explained.

- Did the candidate do anything else that would have shown him/her to be a good team player? Such as taking the initiative to contact social services or asking the patient if the relatives could be involved? (They can become part of the team too.)

This answer basically needs more detail about what was done and why it was done. In addition, the "Result" section is partially addressing the wrong point. As well as highlighting that the problem was satisfactorily resolved, it should emphasise that this was the result of teamwork.

Example of an effective answer

"Three months ago I was on call, taking admissions from GPs and Accident and Emergency. I was the only Foundation Year 2 doctor on-site, with my Registrar being busy in theatre and my consultant on call from home. A patient presented with <Emergency> which required admission and an emergency operation. Whilst I was resuscitating the patient, I asked the Foundation Year 1 to call the Registrar in theatre as I felt it was important to inform him as soon as possible. The Registrar informed the FY1 that he would be busy for at least two hours and I therefore took the decision to call the consultant as well, who announced that he would come in and see the patient.

At the same time I asked one of the nurse practitioners to call the anaesthetist and help prepare the theatre so that everything would be ready by the time the consultant arrived. Throughout this time I kept in constant communication with the consultant in order to ensure that he was fully briefed. The patient was taken to theatre within minutes of the consultant's arrival and made a successful post-operative recovery. By coordinating the team at a time that was stressful for all involved (patient and doctors) I helped achieve this result. This taught me how crucial communication is in ensuring that the whole team functions well."

Note the absence of much detailed clinical information (totally irrelevant for the purpose of highlighting team playing), the concise but informative introduction, and the manner in which the main components of team playing are highlighted throughout the example by the candidate, including:

- Recognising your limitations
- Informing his seniors and keeping them up to date about developments
- Informing other colleagues about developments that are relevant to them (the anaesthetist)
- Using other team members to help out, based on their skills level
- Getting things done (stabilising the patient, preparing the theatre, etc.).

Also note how the conclusion keeps the mind of the interviewer focused on the candidate's skills by not only explaining the outcome in a concise manner but also highlighting what he/she did that made it possible to achieve it, and what he learnt from it. Without this element of reflection, the answer would achieve a low score.

6.10 Do you work better on your own or as part of a team?

This question is often misunderstood and sees candidates rushing to reassure the interviewers that, since they are good team players, they work better as part of a team. The answer is slightly more complex and requires you to demonstrate that, although you are, of course, a good team player, you can also work independently (though still within the remit of a team), i.e. that you are not someone who requires constant support to get on with their work.

One way to structure the answer is to have two sections: one where you describe how you can work independently, followed by a section on how you can also work as part of a team. Alternatively, you can structure your answer around different types of work that you do, showing how you can be independent and also a team player. As usual, you will be expected to back up your claims with examples from your personal practice.

Example of an effective answer

"The answer to this question is that I can work well both as part of a team and independently, depending on what the situation calls for. When I arrive in the morning, I ensure that the list for the ward round is ready on time, with all the investigation results. Although I take full ownership of this task, it is a clearly defined role and often requires me to use my own initiative; by fulfilling this job well, I function as a team player at the same time. Indeed, I need to anticipate what information my colleagues are likely to need when making management decisions; I also often need to liaise with other departments when information is missing, which requires good communication and, sometimes, diplomacy.

When I undertake my audit projects, a lot of the work required consists of data collection and analysis. I like to take full responsibility for all of this and make sure that I deliver what is required by working independently. However, I also involve my senior colleagues when I need to discuss a particular issue relating to the project; and if one of my junior colleagues is keen to get involved, I will make sure that they can take part in the project too.

I think that part of being a good team player is also to be able to undertake roles and work independently, delivering what the team requires of you, whilst ensuring that you maintain constant communication. I feel that it is something that I am particularly good at and my colleagues' feedback is that I am a very proactive and entrepreneurial individual who is, at the same time, very attentive to others' needs and also a very good communicator."

6.11 What makes you a good leader?

What is leadership?
Leadership can be described in three words: – **C**hange – **P**eople – **R**esults

Initiating and implementing Change
A leader is someone who has a vision of how departments or teams should develop or change and is able to drive that change. He/she is able to question conventional wisdom and current practice, to encourage others to develop their own ideas and to implement new protocols, guidelines or new ways of working. This involves building relationships with others, not just within your own environment but also with others outside, to ensure greater collaboration and achieve common goals. Leadership is also about identifying and understanding the impact of internal and external politics and acting accordingly. That involves negotiating and influencing others, building consensus and gaining cooperation from others to ensure that the right information is obtained and that common objectives are achieved.

Developing People (and creating a positive environment)
A leader takes people with him/her towards the objectives that he/she has set and makes sure that he/she creates an environment in which people can develop, work together and cooperate, and where there are good mechanisms in place to resolve conflicts constructively.

Delivering Results
This is the ability to meet set goals and expectations. This includes an ability to make decisions that lead to tangible results by applying knowledge, analysing problems, and calculating risks. Delivering results is the aspect of leadership to which you are most usually exposed as a trainee, and the closest to management. Essentially, it is about organising a team, planning and delegating, and getting things done.

You don't have to be a clinical director to be a leader!

Leadership is a real skill that anyone can demonstrate. You don't have to be a consultant or a chief executive to exercise leadership. I am often struck by the number of people who ask me at my courses: "How do they expect us to demonstrate leadership when we are only trainees?" In truth, you probably started demonstrating leadership very early in your career and even before. For example, anyone who has had to deal with a busy on-call or with multiple emergencies on their own or with limited

resources would be demonstrating leadership – even leading a ward round and the organisation surrounding that may be an example. This section should help you clarify your thoughts and will prompt you to think about your own examples.

Qualities of a leader

From the description of leadership set out above, you can see that, in order to be a good leader, you will need to exhibit the following qualities:

Approachable	Encouraging	Integrity
Assertive	Fair	Open-minded
Clear communicator	Fast learner	Organised
Consistent	Flexible	Patient
Constructive	Good listener	Resilient
Creative	Honest	Supportive
Decisive	Innovative	Tenacious
Diplomatic		

Answering the question

What makes you a good leader will be a mixture of the responsibilities that you take and your personal qualities, both of which you can derive from the issues above. Leadership is a vast topic and you should ensure that you focus on three or four areas or skills that you feel represent you and your experience best; attempting to discuss everything will either result in a very superficial or a very long answer.

Example of an effective answer

"One of my strengths as a leader is that I take ownership of a task, a project or a problem when it is given to me. I also involve the other members of my team to ensure that we work well together towards completing that project. For example, during on-calls I may have several complicated cases to deal with at once; at times the Registrar and consultant may not be immediately available either because they are busy somewhere else, or because they are on call from home. In such a situation, I aim to make decisions about how we should prioritise the patients, which member of the team would be best placed to handle each patient, whether we can deal with the issues by ourselves and how likely we are to require assistance from senior colleagues. As a leader in these stressful situations, I feel that I am very good at keeping the team together by maintaining good communication with everyone, by making myself available if colleagues have queries or questions they want to discuss and also by making decisions when they need to be made. Sometimes this may require seeking advice from someone more senior or more experienced.

As a leader, I am also very supportive and encouraging towards my colleagues, trying my absolute best to encourage my juniors to consolidate their skills and experience, and to develop new ones. For example, when I do an audit, I make a point of involving junior colleagues in collecting and analysing the data. As I review patients in the morning, I also make sure that I identify interesting cases that we could review as a team in order to consolidate our knowledge. I often use these in monthly workshops that I organise for those taking the membership exams and also encourage junior trainees to present these cases at departmental teaching sessions. I have found these activities particularly effective for developing a good relationship between all team members and making everyone feel involved.

Finally, I have a good ability to engage with people, even when conflicts develop. For example, I have had to deal with GPs who insisted that a patient with seemingly little wrong with them should be admitted, with a nurse who refused to administer a drug which she felt contravened hospital policy, with relatives who were adamant that the patient was not being treated well or even with a Registrar who made decisions I believed were not in the best interests of patients. In these situations, I have always been very good at keeping calm (and in fact this is one of the comments that often comes back in my feedback forms) and at trying to find a constructive way of resolving the problem."

This answer is effective because:

- It has three points which are clearly signposted at the start of each paragraph and demonstrate wide-ranging experience, with examples.

- Each point is expanded just enough to show the extent of the candidate's experience.

- The candidate reflects on his skills by demonstrating their impact on others. Bringing feedback into the answer (last paragraph) helps to introduce some objectivity into the answer

- The candidate uses a positive language and also appears realistic by presenting the image of someone who, despite being confident, can also involve others and ask for assistance.

6.12 Give an example of a situation where you showed leadership

Choosing the best example

For this question, you should familiarise yourself with the role and qualities of a leader discussed in the previous questions and try to determine which examples would enable you to best present your leadership abilities.

Initiating and implementing change

- Any situation where you identified a problem in the workplace and took the initiative to implement a solution. Maybe you spotted some inefficiency or lack of compliance, did an audit to identify the extent of the problem and then tried to encourage your team to change its practice. Perhaps you identified some training issues and took it upon yourself to liaise with other key team members to change some aspects of training

- Situations where you held positions of responsibility and were instrumental in making decisions that impacted on other people (for example, if you were on the board of some student committee at medical school).

Developing people and creating a positive environment

- Any team environment/meeting where you have encouraged and managed differences of opinions (e.g. ward round, MDT meetings)

- Situations where you have dealt with a conflict with colleagues in a constructive manner (e.g. underperforming colleague)

- Projects or tasks where you played a key role in encouraging and supporting juniors or other colleagues, developing their skills and abilities by providing feedback and encouragement, and providing them with opportunities to become involved in interesting or stretching projects (e.g. audit, teaching or other projects)

- Situations where you sought to encourage a positive team spirit. This could be either through encouragement whilst dealing with a difficult work situation, or even outside of work (e.g. by organising team events such as quizzes, sport tournaments, etc.).

Delivering results

- Competently managing a difficult case with little senior help
- Dealing with multiple emergencies in an under-resourced environment
- Dealing with a difficult patient or a complaint
- Being confronted with a sensitive problem with no immediate help (e.g. child protection issue or any other challenging situation)
- Facing tight deadlines to complete a complex project (e.g. publication for which you need advice from a senior who couldn't care less)
- Negotiating admission of a patient onto a ward where the ward doctor on-call refused
- Negotiating admission of a patient to ITU where the ITU doctor was reluctant to agree
- Requesting a scan from Radiology, who refused to perform it

- Situation where a GP or another doctor requested something unreasonable and you needed to "educate" him about your position
- Any negotiating situation outside of medicine, for example if you were in charge of organising an event, or part of a committee, and had to influence other people to help you with your project, when they were reluctant to engage.

Delivering the answer

Delivering the answer should be done using the STAR approach, ensuring that you use the story as a backdrop to your leadership skills (the whole point of the question is to give you an opportunity to show off your leadership skills, and not just the story itself).

Example of an effective answer

Situation/Task	"A few months ago, a child was admitted onto the paediatric HDU ward feeling unwell with diabetic ketoacidosis. During the night, the child's condition deteriorated.
Action	Since the change was significant and unexpected I informed the consultant so that he could advise then and, should I need his help later on, he would be aware of the situation. At the same time, I also informed the anaesthetist and asked for his assessment in case the child required ITU admission later. I started to manage the child accordingly, using an established protocol, and he gradually showed signs of improvement. I therefore decided it was safe to keep the child on the HDU and organised for nurses to check the child at 30-minute intervals and let me know of any changes in his condition. This enabled me to provide care to other patients whilst keeping up to date with the child's development. I also explained that I would return to review him once I had checked on other patients. In the meantime, I met up with the boy's parents in order to keep them updated on their son's situation; this provided them with information, a chance to ask questions and some reassurance. I also arranged for a nurse to check regularly on them to make sure they remained happy with developments. Throughout the process I kept my consultant involved where necessary; this meant he had a clear picture of events and would be able to answer any questions from parents later. As the child's condition improved further, he was transferred to the general paediatrics ward, at which point I involved a diabetic nurse and a dietician who talked to the child and the parents about insulin and the importance of diet.
Result	When the consultant arrived, the parents were keen to discuss their son's care with him. With the advance information I had provided for him, he was able to see the parents very quickly after reviewing the child and his notes. This proved very reassuring for the parents; they also told him that they had been really impressed with the care I had given to their son and the explanation they'd received from me.
Reflect	This was a medical emergency. I placed the patient's care and treatment as the highest priority, I was working with a good team and with good planning, delegation and appropriate communication everyone understood their role and completed it well. By carefully coordinating the actions of a wide range of colleagues, I was able to make sure the team delivered efficient and safe care to the patient and his family."

This example is effective because it describes in detail the candidate's actions, with sufficient but not excessive clinical information, and clear reflection at the end of the answer.

6.13 Tell us about a mistake that you made

What the question is testing

This question is testing your ability to recognise that you make mistakes, to take responsibility for your mistakes, to sort them out, to reflect on your experience, modify your behaviour accordingly and ensure that others benefit from your experience too.

Many candidates are reluctant to discuss their mistakes because they feel that it will present them as bad doctors. However, with this question, the interviewers are trying to establish that you are safe in a realistic context; as far as you are concerned, this means demonstrating that, when mistakes happen, you can deal with them appropriately (and not that you never make mistakes. If you said that, you would score zero).

Structuring an answer

You will need to follow the STAR structure. For this question, this will mean bringing the following items into your answer, all of which would be reflected in the marking scheme:

Situation/Task	Describe the scenario (keeping the clinical information to the strict minimum necessary to the comprehension of the story). Explain what the mistake was and its impact (i.e. how did that affect the patient, if at all).
Action	Explain the clinical steps that you followed to resolve the problem and make sure that the patient was safe. Describe which other members of the team you involved and why you needed to involve them. Describe how you communicated with the patient or relatives about the mistake made (this is often neglected by most candidates, thus costing them valuable marks).
Result/Reflect	Reflect on the scenario and explain what you have learnt from it. Explain how it changed your practice, perhaps giving a quick example of a different situation where you acted differently. Explain how you ensured that others learnt from it (for example, by raising the problem at a team meeting/ sending an email to others). If you completed a critical incident form, don't forget to mention it.

Which mistakes can you mention?

A good answer will discuss a mistake which is:

- Personal, i.e. your mistake and not that of another colleague. If you talk about someone else's mistake you will miss the opportunity to demonstrate your own integrity.
- Interesting, i.e. which has some element of drama. If the mistake is boring to describe, it is likely to score low. Similarly, if you choose a mistake that is fairly common then you are less likely to impress, unless the consequences were significant enough to make the whole answer interesting.
- Safe. You don't want to appear completely incompetent. Safe does not mean that no harm was caused to the patient, but that if there was harm or risk of serious harm you identified it quickly and took immediate steps to resolve the problem. You do want to avoid discussing a mistake where the patient died, though. Answers of the type "The patient died but I learnt a lot" never sound that impressive. Examples which are safe would include any near misses, any situation where the patient was inconvenienced or non-emergency care was delayed, or even any situation where the patient was placed at risk but you recognised it before much harm could be caused. Everyone on your panel will know what being a junior doctor is like. There is no point pretending that you are perfect.
- Good learning ground. Half the marks will relate to the learning points that you drew from the experience and how you changed your practice. If your example is too safe, you are unlikely to have any interesting learning points and will end up scoring a low mark. For this reason you want to

avoid any mistakes which are not yours, any mistakes which are caused by a system failure and, for surgeons, any mistakes which are in fact recognised complications since it is only with hindsight that you could say that something could have been done differently.

Here are a few examples of mistakes that could be used. For all clinical mistakes it is important to include the fact that you completed an incident form. If you did not, be prepared to justify this – you may have to admit that the failure to do so was an oversight and a learning point in its own right. This should help you think about your own experience and formulate your own answer:

- Flushing a venflon with lidnocaine instead of saline because the label looked similar and since you were in a hurry you did not take the time to double-check. You would explain how you managed the patient clinically after the mistake was made (moved to resus, cardiac monitoring, called for help from your Registrar, anticipating potential complications and ensuring that all bases were covered). You would then raise the issue of patient communication including reassuring him/her, explaining how you plan to deal with the consequences, apologising and mentioning how you plan to ensure that the same mistake won't happen again. You can then discuss how you changed practice as a result (e.g. this taught you the importance of double-checking your actions) and how this led to a change in the labelling system.

- Giving a patient a dose of antibiotics, not realising that they were allergic. This could have happened because you made the assumption that they were not allergic (the drug chart did not say so, or you just did not remember to check) or perhaps because the bracelet indicating they were allergic was hidden by a bandage. In your answer, you would explain how you kept an eye on the patient to ensure that they did not develop any problems. Hopefully, the patient did not react in this particular case; otherwise you will need to explain which steps you took to treat the clinical problem. Explain that you called for help and communicated with the patient appropriately (explaining, reassuring, apologising). Finally, reflect on the reason why you made the mistake and how you have since changed your practice.

- Discharging a patient with inappropriate medication. You may have spotted the mistake yourself and recalled the patient, or the mistake may have been spotted because the patient turned up a few days later with a more severe problem.

- Failing to plan for a potential complication prior to performing a procedure, as a result of which you were not prepared when it did happen. You then had to call for help to resolve the problem. For this mistake to be effective, you will need to discuss a complication that you should have planned for but somehow didn't. If no one ever plans for it because it is rare then it isn't really a mistake.

- Failing to take into account a patient's co-morbidities (perhaps you were in a hurry, or the notes were so thick that you made assumptions).

The above mistakes are all of a clinical nature. There are other mistakes you can discuss, which are of a managerial or communication nature. These include:

- Delegating a task to a colleague (e.g. junior doctor, nurse) assuming that they would know what to do and how to do it. They didn't and, as a result, patient care was delayed and/or confusion ensued.

- Communicating important information to a patient assuming they would understand it, when in fact they did not. As a result, they did not comply with your instructions. This could be because you were falsely reassured by their behaviour towards you or because you forgot to check their understanding.

- Being a bit too direct with a patient, not realising that in fact they were very sensitive. As a result, you risked causing them more distress than intended or compromising their trust in you.

At an interview, you can mention any mistake, unless the interviewers have directed you towards one particular type. For example, if simply asked for "a mistake", you could mention a clinical or non-clinical mistake. If asked specifically for a clinical mistake, then you would need to find a clinical sce-

nario; fobbing off the interviewers by presenting a non-clinical scenario would result in a low mark. If in doubt, ask them.

Some interviewers will ask for a *recent* example. This usually means the last 6 to 12 months.

Playing safe v taking risks

Having viewed the feedback received by hundreds of candidates over dozens of specialties, I can comfortably say that those who score the highest on this question are candidates who present mistakes where they were actively involved and from which they will have learnt a lot from a personal point of view.

Before the interview, you must decide whether you wish to play safe by presenting an average mistake or a non-clinical mistake, thereby guaranteeing yourself half the marks; or whether you want to be more daring by presenting a more dramatic mistake, which, although risky, may yield you much higher marks if you can explain it properly using the steps highlighted earlier.

6.14 Describe a situation when you demonstrated professional integrity as a doctor

Many candidates have little understanding of the word "integrity", which then leads to poorly positioned answers. Integrity is a crucial part of the GMC's *Good Medical Practice* and you should therefore show a good understanding not only of the concept but also of how it impacts on your work on a daily basis.

Integrity in your day-to-day work

Integrity refers to your ability to do the right thing when it may be tempting to react unethically for the sake of an easier life. This may be:

- Situations where you have made a mistake, where you would be expected to own up to it and take corrective action (see previous question).
- Situations where you should know how to handle a particular issue but somehow you don't. Integrity is about admitting your lack of knowledge and working towards addressing it (a lack of integrity would be pretending that you know what to do, which may put your patients and colleagues at risk).
- Situations where you discover that something is wrong and where you take proactive steps to address the situation (for example, if you discover that one of your colleagues has made a mistake, is an alcoholic, takes drugs, has abused a patient or is underperforming/incompetent).
- Situations where you were pressurised to do something that you knew or felt was wrong and where you resisted the pressure (e.g. a relative, a friend or a colleague encouraging you to breach patient confidentiality or a patient wanting you to prescribe a treatment that you know would not work).
- A colleague who wanted a favour that would place you in a difficult position (covering up for a mistake they made, prescribing them controlled drugs, etc.).

Example of an effective answer (using the STAR approach)

Situation/Task	"In my Foundation Year attachment in General Practice, a mother came in with her child, who had a cough, fever and sore throat. The mother insisted that her baby had a chest infection and demanded antibiotics. After a thorough examination of the child, the chest was clear and I diagnosed viral upper respiratory tract infection. In the short term, the child only really needed paracetamol, rehydration and steam inhalation.

	The mother became slightly irritated at the fact that I did not wish to consider antibiotics and after having spent some time explaining to her in simple terms why antibiotics would not work in this situation, she did not show any sign of changing her position. She indicated very strongly that she felt I had not been trained properly and that any good doctor would give her the antibiotics she was requesting. She demanded to see my consultant.
Action	The mother was placing me under a lot of pressure to give her what she wanted by attempting to intimidate me. It was important that I kept my cool and did not give in simply to get rid of the problem that I was facing. I provided the mother with a couple of leaflets regarding sore throat and cough from the PRODIGY guideline and told her that I would refer the issue to my consultant for advice straight away. My consultant explained that the best way forward would be to offer the mother a back-up antibiotic prescription and ask her to come back for it if her child did not improve after two days. I explained to the mother that I would compromise by getting her to follow my advice whilst the back-up prescription, in line with her wishes, would give her the reassurance of antibiotic back-up.
Result/Reflect	The mother left happy and came back to thank me after the child got better without the need for antibiotics. In this situation I maintained my integrity by remaining professional in my relationship with the patient despite the pressure that she was placing on me, by not giving in to a request that I deemed against the best interest of the patient. It also helped to dissipate her anxiety and maintain my credibility by involving a senior colleague appropriately. This example also illustrates the importance of communication in dealing with potential conflicts. In this case, by remaining civil, I avoided a potential complaint."

The STAR approach provides a clear structure for the story. Each step is properly explained from the candidate's point of view and there is a good level of reflection at the end. The example also clearly shows the candidate as someone who took responsibility for sorting the problem out, highlighting, where appropriate, how professional integrity was maintained.

6.15 How do you handle stress?

This is a generic question where there is a risk of giving the same answer as hundreds of other candidates and, therefore, where you need to illustrate each point with personal examples in order to stand out. The marking schedule for this question will typically be rewarding:

- The variety of ways in which you can deal with stress
- Your ability to identify that you are getting stressed
- Your ability to show the relevance of the information to your work (i.e. by bringing personal examples, and, in the case of your hobbies, by explaining what you gain from them).

Many candidates fall into the trap of concentrating on their hobbies. In reality, interviewers will be looking for a broad range of ways of dealing with stress, including in the workplace. Note that the question does not explicitly ask how you recognise that you are stressed; however, it is a sad fact that many marking schemes allocate marks for relevant information that is not always explicitly requested. When in doubt, you should aim to provide an answer which is as complete as possible by looking beyond the exact wording of the question and providing other relevant information. If your interviewers are helpful, they may prompt you for that information; others have higher expectations and may not be so kind.

Handling stress

There are different types of stress to which you may be exposed both at work and in your personal life. Depending on the type of stress that you are facing, you will react and cope differently. This may include:

For stress caused by busy situations (e.g. being overworked):

- Taking a step back
- Remaining calm
- Organising your work, prioritising and delegating
- Trying to anticipate difficult periods and planning accordingly
- Taking appropriate breaks
- Breaking tasks off into smaller, more manageable chunks
- Asking for help from your colleagues
- Communicating well with others (e.g. maintaining momentum in a team to ensure full coordination)
- Managing others' expectations (for example, if you are prioritising, inevitably someone's main priority will become bottom of your list. Not managing their expectations would potentially result in a conflict).

For stress of a more emotional nature (e.g. difficulty in dealing with negative issues such as personality clashes, patient deaths, high expectations from others, feeling of powerlessness)

- Sharing your problems with colleagues
- Discussing problems with your friends and family.

For general stress (e.g. accumulation of fatigue)

- Socialising with colleagues or friends
- Having time for yourself, hobbies, centres of interest outside medicine.

Rather than simply list some of the above items, you should focus your answer on your personal experience, explaining how you deal with a range of different situations that you commonly face in the workplace. Since the question is not specifically relating to the workplace, you may also mix some information relating to other settings if you feel that they are appropriate.

Example of an effective answer

"I deal with stress differently depending on the situation. For example, during my on-calls, I often have to deal with multiple admissions on my own, some of which can take a long time to handle. In such circumstances, I find it very useful to take stock of the situation once the most urgent matters have been attended to. This ensures that I remain in control of the situation and do not miss any important tasks. If I feel that an issue may cause problems later on, I keep in touch with my Registrar so that he is aware of the situation and able to provide input as needed. I also work closely with the nurses because they are invaluable in getting some of the tasks done very efficiently and often provide very useful information that I can use to make more informed decisions for our patients. When I am very busy, I try to take a short break to have a coffee. I find that having regular breaks really helps to keep me focused.

When I worked in Elderly Care, I found many relatives had unreasonably high expectations; this could be stressful at times. Although I could see that they had their family member's best interest at heart, I found they were often keen to blame the medical profession for a patient's lifestyle excesses, poor adherence to treatment or general poor health. This created a sometimes very negative and stressful atmosphere. Generally speaking, I was able to deal with this because I felt that they reacted in this way as a result of a natural concern for their relative. If ever I feel that the tension is rising or that I may be using a more aggressive tone of voice, I take some time out to rethink my approach or to consult a colleague on the best approach. It can be very useful to discuss problems with colleagues as it provides an opportunity to share the problem with someone else but also to understand how *they* deal with similar issues. Often, we both learn from these conversations and I have found that, since I have been talking to them in this way, they have started to do the same with me. This has led to better team working, which has further reduced stress.
I think that the key to a stress-free life is to make sure that you are properly conditioned to deal with problems. I have often found that I react much more calmly to problems when I have had the opportunity to relax outside work. Personally, I enjoy playing sport with friends, particularly cricket. I also enjoy reading books such as crime novels and history books. I find that, by combining group and personal activities, I strike a good balance in my leisure time which then makes it easier to deal with stress generally.

Friends and colleagues often comment that I am a relaxed individual but I know that stress is beginning to affect me if I start to find it difficult to think straight or become irritable or disorganised. When I recognise this I make sure that I set aside some valuable relaxation time, usually in the evening, to stop letting the stress get to me."

6.16 What is your main weakness?

This question is often a worry for candidates, who fear that they may sound too clichéd or uninteresting by using a weakness that the interviewers are likely to have heard several times that day.

What is this question about?
Contrary to some of the interview myths which circulate, this question is NOT about demonstrating that you are perfect and that you have no weaknesses. On the contrary, the interviewers will be testing your honesty, your insight, your ability to learn from your mistakes/problems and to develop as an individual. Rather like the question on a mistake that you made (see 8.17), they expect you to talk openly about your own failures: an honest doctor is a safe doctor whom patients and colleagues can trust. So, don't be afraid to be personal as this is the only way in which you can maximise your mark.

Where do people go wrong when answering this question?
The problem does not lie so much in the weakness that candidates choose to mention in their answer but in the way it is delivered. Most answers sound clichéd because candidates present the weakness in a simplistic, almost black and white, manner. A common answer is of the format: "I can't say 'no', but I am aware of it and I am working on it." In such an answer, there is no attempt to explain exactly how they are dealing with it. This makes the answer very standard and totally uninteresting.

There is also no real attempt to explain in any detail what the impact of the weakness on the candidate is, for instance by providing an example which would lift any ambiguity. The lack of example means that the interviewers are left to extrapolate from the basic statement made by the candidate in any way they like and the candidate therefore loses control over the way in which their message is received.

For example:
- "I can't say 'no'" may give the impression that you are weak
- "I have high expectations of others" may give the impression that you are a control freak and unfriendly.

How to choose a good weakness

There are three parameters that you need to consider to choose a suitable weakness:

- Make sure that it is one of your real weaknesses as you will be much more at ease talking about it in detail than if you make it up (answers which are faked tend to sound rehearsed, vague and clichéd).
- Choose a weakness that, in different circumstances, can be considered a strength. The strategy is to present the weakness as a strength which can sometimes become a problem.
- Choose a weakness that can be remedied. There are weaknesses which can be difficult to correct, such as being disorganised, or getting frustrated at certain events. These are best avoided.

Examples of weaknesses

There are numerous examples of weakness that you can use, some being more original and creative than others. It is important that you choose one that you are comfortable talking about, as most of the impact that you will have in delivering the answer rests in your tone of voice and general confidence.

If you are unsure as to which weakness to choose, try different examples and see which one sounds best. I have set out below a range of weaknesses that you may want to consider, listing their negative and positive interpretations, together with some means of dealing with them. See if they are true to your situation and, if they are, adapt them to match your situation, bringing your own examples into the answer.

Being a perfectionist
This answer is probably one of most quoted at interviews, and one which is least likely to make you sound credible. By itself, it is not a bad weakness to mention but the interviewers will have heard it so many times in one day that you may just be subconsciously penalised for your lack of originality. If you want to use the "perfectionist" answer, I would advise you to find a more specific slant to the weakness so that you do not present it under such a broad heading. Some of the weaknesses have a "perfectionist" slant to them but sound less clichéd.

Finding it difficult to say "no"
This is also a commonly given answer, but perhaps a little less clichéd than the "perfectionist" answer, primarily because it has more words to it and therefore the impact is softened. If you want to use this weakness, you will need to convey the meaning of not being able to say "no", without actually using that phrase. For example: "there are times where I take on so many simultaneous projects that it can be difficult to juggle them all." The meaning is the same, but the wording is a bit more original.

Positive: You are a good team player, a good colleague, and always willing to help.
Negative: You may take on too much work and get stressed, or fail to deliver on some projects (hopefully minor ones!).

What you can do about it:
- Learn to become more assertive (more experience, course)
- Learn to manage colleagues' expectations (so that they are okay about you saying "no")
- Work with colleagues to help them find alternative solutions
- Be more realistic about your ability to deliver and more open with colleagues about issues
- Be more proactive in delegating to others so that you can say "yes" without having to take on everything yourself.

Having high standards and a tendency to expect others to follow the same standards as you
Positive: Being driven, you have achieved a lot and you deliver results to your team above their expectations. You have also encouraged others in your team to achieve and they did well as a result. You are seen as a good motivator and a "doer".
Negative: Some of your colleagues may not be able to follow your pace. You are trying to impose methods and principles which they may not adhere to and this may cause friction at times (i.e. you risk being seen as controlling).

What you can do about it:
- Learn to be a bit more flexible with colleagues. Take the time to know them. It may give you ideas about how you can approach them.
- Ensure that all team members have been trained in the skills you are expecting them to perform.
- Be more open-minded in your approach and accept that others may have ideas which are as good as, if not better than, yours.

Having a direct style of communication
This weakness is not suitable for specialties where communication is an ultra-essential skill (such as Paediatrics, Psychiatry and any fundamentally holistic specialty). However, if addressed properly, it can be used successfully for a wide range of specialties, from surgical specialties to general medical specialties and even specialties such as Public Health.

Positive: People know where they stand with you; they know that if they ask for your opinion they will get an answer which they can use towards their own thinking process. Generally, you find it easy to be trusted because people know that, if there is an issue, you will discuss it openly.

Negative: There are times when more subtlety and diplomacy is required, and you may encounter situations where communicating too openly may cause friction.

What you can do about it:
- Learn to appreciate the impact of your communication on others
- Learn to recognise when you can be yourself and when you need to soften your style
- Seek guidance from seniors; perhaps go on a course.

Finding it difficult to delegate
This weakness is the result of lack of experience of working in a delegation environment. This lack of experience, coupled with the fear that you may lose control of the situation, leads to your taking over the situation.

Positive: You deliver consistently good results and, in an environment where most people rotate frequently, it can be an asset not to overload new team members until they have established their ability.

Negative: People may see you as someone distant (sometimes). Also, by trying to do everything yourself, you end up having too much on your plate, with a risk of getting stressed.

What you can do about it:
- Be more attentive to juniors and find opportunities to delegate
- Get to know your colleagues early on so that you find it easier to trust them and therefore delegate
- Discuss with your seniors and/or go on a course.

Tendency to take criticism or negative outcomes personally
This weakness can work well if you have the right type of personality. I would not recommend it for surgical specialties though where interviewers can be less forgiving about a lack of confidence than in other specialties.

Positive: Taking things personally pushes you to act on problems quickly.

Negative: Being over-negative may make you appear under-confident (and miserable)

What you can do about it:
- Discuss with colleagues and see how they deal with criticism, complaints and negative outcomes
- Use every incident as an opportunity to learn.

Getting too involved with patients
This would refer to situations where patients have many issues and where you find it difficult to put a stop to a consultation for fear of missing something out or upsetting the patient.

Positive: You are thorough and caring.
Negative: You can overrun and/or get stressed

What you can do about it:
- Learn to become gently assertive
- Discuss with colleagues to understand how they do it.

Getting too attached to patients
This refers to situations where you are struggling to maintain the professional barrier in your dealings with a patient and push the empathy to a point where it personally affects you psychologically.

Positive: You are caring and empathetic.

Negative: You get stressed.

What you can do about it:
- Learn through experience to keep the appropriate distance
- Discuss with colleagues/seniors.

Taking your worries home with you
This refers to situations where you finish your work and feel the need to double-check things when you get home or keep worrying about whether your instructions will be followed once you have left. In some cases, this may result in your having to call the ward once home, or even to stay late to ensure that things are done properly.

Positive: You are thorough and conscientious.

Negative: You may get stressed or even irritate others, who feel you don't trust them. It may also interfere with your social/private life.

What you can do about it:
- Optimise your communication with colleagues so that you can be sure they know what needs to be done
- Discuss with colleagues how they deal with it
- In the more extreme cases, call the ward once only when back home so that you then have your entire evening clear afterwards.

All these are examples, which will work well if they are explained in a personal manner. There are other approaches that you can adopt, but which, in my experience, are less successful. These include:
- Using a weakness which is not linked to personality but to something practical, such as lack of research. Most marking schemes would be based around a personality-based weakness and therefore using a more practical weakness may score lower. If you have any doubt, or if you are really keen to talk about a non-personality-related weakness, then there is no harm in asking the interviewers whether they want a personality-based weakness or whether you can use something relating to your training.
- Using a weakness which is in the past and already resolved. This does not answer the question, which is "What is your main weakness?". Using an old weakness would not demonstrate that you have any insight into your current behaviours and therefore may score lower. Under the new ST interview system experience shows that playing safe rarely pays off. There is a benefit in taking risks.

Structure to answer the question
There are many ways in which you can answer this question; however, having heard thousands of people answering this question both in my experience of interviewing and in my coaching experience, I have found the following structure to be one of the most effective:

Step 1:	**Quick positive introduction** to place a positive context on the weakness (this must be no more than 15 seconds or so, otherwise you will give the impression that you are avoiding the question).
Step 2:	**State the weakness and explain the negative impact it has**. In doing so, ensure that you use words which do not make the weakness sound awful. "I can't delegate effectively" sounds bad, but "I sometimes find it difficult to delegate, particularly when working with new junior colleagues" is more specific and more realistic too.
Step 3:	**Give a specific example** of a situation which illustrates the weakness. Spend some time on this section. The purpose of the example is to remove any doubt in the interviewers' mind about the seriousness of the weakness.
Step 4:	**Explain what you learnt from that situation.** This will enable the interviewers to visualise exactly how reflective you can be. This, together with the next step, is one of the most important parts of the answer.
Step 5:	**Explain how you attempt to deal with the weakness generally.** This will ensure that the interviewers tick the marking box which says "Takes concrete steps to remedy the weakness".

Example of an effective answer
It would take hundreds of pages to illustrate how each weakness can be discussed; however, once you have read the following sample answer, you will get the idea of how the above structure can be applied and you will have no problem adapting it to your own experience and circumstances. I have chosen the weakness of "taking on too much" to demonstrate how you can build the answer using the different steps stated above.

Step 1	“I have always been an ambitious person and, as a result, I always show a lot of enthusiasm in getting involved in all sorts of projects. If you look at my CV, you will see that I have achieved a lot, not only in terms of clinical experience, but also in terms of audit and teaching experience.
Step 2	However, there are times where I have been a little too greedy and became involved in too many projects at once, as a result of which I either placed myself under too much pressure, or I had to arrange an extension of the deadline.
Step 3	One example that springs to mind is a situation which arose last year, when, as well as doing 1:4 on-calls and studying hard for my Part 1 membership exams, I had agreed to deliver quarterly lectures to medical students, volunteered to do some number-crunching for my consultant’s research project and also agreed to do two audits, one of which I was keen to lead throughout. After two months, I could see that I would never be able to complete all this before I moved to my next post and so I had to go back to my consultant to explain that I could only do one of the audits.
Step 4	I felt I had let down my colleagues in this particular instance, but it made me realise how crucial it is to be aware of your own capacities and that, although you may look good when you accept a project, it can cause problems if you don’t deliver. On reflection, I also feel that I could have delivered as expected if I had thought about involving someone else when there was still time to do so, such as a medical student, who could have made a start on collecting the data.
Step 5	I have become very aware of the problems associated with getting involved in too many projects and the impact both on myself and on other people. As a result, I try my best to think carefully before launching into new projects (without curbing my own enthusiasm, of course). I also try to involve others more when appropriate, which has the advantage of getting juniors involved in new projects too.”

7 Clinical governance & academic questions

Questions on academic activities (e.g. teaching, research) or on clinical governance are increasingly common at CT and ST interviews. These can be generic (e.g. “What is clinical governance?”) or specific (e.g. “How does risk management affect your daily practice?”).

They are generally easier to prepare for than the more personal questions addressed in previous chapters because they are factual and therefore rely, to a large extent, on information that you will have learnt before the interview. However, to achieve a high mark, repeating information learnt by heart will not be enough; you will be expected to reflect on your own experience and provide a more personal slant to the issues raised. This chapter will provide you with essential information that you may need at your interview.

In some academic and clinical governance stations, you may be asked to discuss a paper that you have read recently; I would therefore advise you to read the journals appropriate for your preferred specialty before the interview so that you can approach such a question confidently.

On occasion, the interviewers may ask you to critically appraise a specific paper, which you will be given a reasonable amount of time to read prior to the interview (anything between 20 and 60 minutes). To perform well, you will obviously have in mind a process to critically appraise a paper; this chapter will also help you considerably with this task.

7.1 Tell us about your teaching experience.

This is a fairly straightforward question, where you can easily shine provided that you give an answer which goes beyond the obvious day-to-day informal teaching experience that you may have. Indeed, most marking schemes allocate very few marks for informal teaching experience and reward candidates who show more initiative and enthusiasm towards teaching. To optimise your marks, you will need to provide as much information as possible in each of the following sections.

Section 1: Actual teaching experience

You can structure this section in two ways:

Structure 1 Different types of teaching	Structure 2 Different types of groups taught
▪ Informal teaching ▪ Lectures (big groups) ▪ Workshops (incl. ALS) ▪ Presentations - Departmental - Grand round - Regional	▪ Undergraduates ▪ FYs & STs ▪ Others (e.g. nurses, GPs, paramedics) ▪ Teaching outside medicine (if you do some)

Whatever structure you choose, you will need to describe the extent of your teaching experience, covering:

- the types of groups you have taught
- the teaching methods you used (e.g. simulation, role play)
- the types of topics that you taught (e.g. clinical knowledge/skills, procedures, history taking, breaking bad news, etc.).

Most marking schemes allocate further marks if the candidate has organised teaching sessions and/or written teaching material from scratch (as opposed to simply delivering teaching to a group of people). Therefore, if you have shown initiative in organising teaching groups or in writing your own lectures, make sure that you highlight it clearly.

Describe how you plan your teaching to meet the needs of the learners and how you use questions and answers to monitor their progress and understanding. Do you use any form of MCQ/quiz at the end to assess their learning? Do you evaluate the process of your teaching (i.e. how it went and what you could do to improve)?

Section 2: Teaching courses attended

If you have attended any teaching courses, mention them. They will form part of the marking scheme and will reflect the care that you demonstrate in developing your skills.

Do not limit yourself to stating that you went to a course; explain also what you gained from it and how it helped you improve your teaching skills. Remember: the more personal your answer is, the stronger its impact.

Section 3: Feedback

- ***Collecting feedback***
  The interviewers will want to know that you take teaching seriously and that you make an effort to find out what others think of your performance. This will portray the image of someone who is keen to improve constantly. In this section, you should therefore explain how you seek feedback from those you teach. Hopefully, this will be through formal means such as a questionnaire being distributed at the end of the teaching session. However, if you have not collected formal feedback, then you can of course talk about how you collect informal feedback from colleagues.

  Generally speaking, introducing qualitative feedback into your answer (e.g. "The vast majority of the students enjoyed it because …") will have a better effect than presenting quantitative feedback (e.g. "All of the medical students gave me 9/10").

- ***Nature of the feedback***
  As well as explaining that you collect feedback, you can push the answer further by stating what that feedback is (limiting yourself to the positive feedback). Sell yourself by stating what others think of your teaching (e.g. that you are very organised, very good at expressing complex ideas in simple terms, good at anticipating the audience's needs).

Section 4: Why you enjoy teaching and future plans

The marking schedule will allow for your enthusiasm and commitment. You should therefore emphasise how important teaching is in medicine and explain what you enjoy about it (see question 9.2 for ideas). If you have specific plans for the future, e.g. taking up a medical education degree or getting involved with Royal College teaching and training initiatives, then you should mention them.

7.2 How do you know that you are a good teacher?

Many candidates often rush to list the skills and attributes that make them a good teacher (i.e. basically, they answer the previous question instead: "What are the qualities of a good teacher?"). This question is not about whether you are good but about how you *know* that you are good. There are many ways in which you may know that you are good, including:

- Positive feedback from colleagues. The feedback could come either from a form that you distribute after each of your sessions, from formal feedback at appraisals (360-degree feedback or MSF – multi-source feedback)

- Being asked to become an instructor on an ALS course (or other similar course)

- Being re-invited to teach at a course (thus indicating that the first time was successful)
- Objective measures of success such as colleagues passing their exams as a result of your teaching
- Visible improvements on the shop floor, for example a junior becoming much more efficient and safer doing a procedure that you taught him
- The way in which your students interact with you during teaching sessions, i.e. the interest they pay to the topic.

When you deliver your answer, do not simply list some or all of the above. Each time you bring up a point, illustrate it with experience. For example, do not just state that your feedback was positive. Describe what the feedback was (stick to the positive feedback). If you have been re-invited to teach at a course, explain why this was the case. What did they like about you the first time round?

7.3 What is clinical audit?

With this question, the interviewers will be testing your understanding of the audit process and therefore you will need to go well beyond giving out a simple definition. They will be expecting you to raise two points:

- A clear explanation of what an audit is, i.e. a definition in your own words
- A description of the audit cycle.

Definition of clinical audit

There are several definitions of clinical audit, some of which date back to 1989 and 1983. However, the most recent is that published in *Principles for Best Practice in Clinical Audit* (2002) by the National Institute for Health and Clinical Excellence (NICE):

> "Clinical audit is a quality improvement process that seeks to improve patient care and outcomes through systematic review of care against explicit criteria and the review of change. Aspects of the structure, process and outcome of care are selected and systematically evaluated against explicit criteria. Where indicated, changes are implemented at an individual, team, or service level and further monitoring is used to confirm improvement in healthcare delivery."

At an interview, beware of trying to regurgitate definitions. Most are lengthy, use words which are not natural to you, and sometimes are deliberately vague to cover wide areas. Your task is therefore to transform this definition into something more easily digestible. For example:

> "Clinical audit is a review of current health practices against agreed standards, designed to ensure that, as clinicians, we provide the best level of care to our patients and that we constantly seek to improve our practice where it is not matching those standards"

or

> "Audits are a systematic examination of current practice to assess how well an institution or a practitioner is performing against set standards. Essentially it is a method for systematically reflecting on, reviewing and improving practice."

The audit cycle

Some of the marks for this question will relate to your understanding of the audit cycle. Make sure that you can discuss each of the following steps without hesitation:

Step 1: Identify an issue or problem

The aim of an audit is to ensure that your clinical practice is in line with best practice. Doctors should continually audit their practice, ideally doing frequent rapid audits (e.g. the last five patients with diabetic ketoacidosis) and making changes. This is much more useful than a larger audit as it is unlikely that there will be many more learning points from reviewing 100 patients than from reviewing five, and the benefit still comes from improving the system and re-auditing it. Primary target topics for audits may include:

- Any area of clinical practice where problems have arisen; this could have been identified through a rising level of complaints, the occurrence or recurrence of mistakes.
- The need to check compliance with national guidelines.
- Areas of clinical practice where there are clear risks either because they deal with a high volume of patients or because there are high costs associated with these procedures/practices.
- Any obvious areas where improvements can be brought in (often identified through observation or experience).

Step 2: Identify a standard

Clinical practice will be assessed against a standard which needs to be defined at the outset. Standards should be drawn from the best available evidence and in many cases are set by NICE, the relevant Royal Colleges, or other specialty-related associations (e.g. British Orthopaedics Association). When standards are not readily available, a Trust may define its own local standards. A Trust may also want to impose on itself standards which are more stringent than those available.

Step 3: Collect data on current practice

The data should be collected in respect of a pre-agreed period of clinical practice (e.g. period between date 1 and date 2) for a specific group of individuals (e.g. all asymptomatic patients who presented to clinic for the first time). These criteria will have been agreed at the outset. In collecting data, care should be taken to ensure that any patient identifiable data is removed.

Note that there are clinical audit departments in hospitals that exist to support your audits! As such, they will help design proformas, collect notes, possibly even do any statistical analysis required, and then help present the data. The important thing is to start early and communicate with them.

Step 4: Assess conformity of clinical practice with the standard

Once the data has been summarised and analysed, the result is compared to the standard to determine how well it has been met.

More importantly, if the standard is not met, the reasons for non-compliance should be identified so that they can be remedied. Although identifying non-compliance is relatively easy, identifying why there is a problem may take more time. In some cases, it may be necessary to carry out a study of the problem to understand the causes of the underperformance.

Step 5: Implementing change

This is the step that justifies the whole process i.e. improving practice so that the standard is matched. Examples of changes may include:

- Altering protocols (especially simplifying them)
- Reorganising service, altering roles and responsibilities
- Providing further training to key staff
- Raising awareness of guidelines with staff (e.g. regular teaching sessions, creation of an intranet)

- Improving documentation
- Altering a labelling system
- Changing equipment.

Step 6: Closing the loop: re-audit

Once all changes have been implemented, the dust should be allowed to settle. After an agreed period of time, once the changes have had a chance to have an impact on clinical practice, clinical practice should be audited again to measure their impact. To be effective and meaningful, a re-audit should use the same sample, methods and data analysis. Hopefully, the re-audit will show that the standard has been matched. If not, further changes will be required and further re-audits should be carried out.

Carrying out the re-audit is commonly referred to as "closing the loop" or "completing the audit cycle". This is by far the weakest point of the process, partly because of turnover of staff and partly because the process of audit still remains poorly understood.

Note: it may be that, in the meantime, the standard has changed (e.g. in view of new research). In this case, the re-audit will constitute a new audit and it can be referred to as the "audit spiral".

7.4 Tell us about an interesting audit that you did.

Structuring your answer

This question is designed to test your understanding of the audit process/cycle through the description of one example. To demonstrate that you understand clearly the principles of audits, you should therefore aim to address explicitly the following points:

- ***Why the audit was deemed necessary*** (i.e. what was the problem which led to the initiation of an audit?).

- ***The standard used.*** Typically this would be guidelines from a Royal College or some other association; but it may be that you had to derive your own standard by doing a literature search for example. If this is the case, be sure to mention it.

- ***The result of the audit,*** i.e. did clinical practice match the standard and if not, why not?

- ***What proposals for change you made and which were implemented***

- ***Whether you did a re-audit or not.*** If you did not do the re-audit (which will be the case for the vast majority of candidates), make sure that you demonstrate your understanding of this crucial step by saying something such as "Since this was the end of my attachment, I did not have time to be involved in the re-audit, but we planned it for 6 months down the line". If you have taken the trouble to check the results of the re-audit with the local team then this would be to your credit, because it would demonstrate the effectiveness of the changes that you had proposed and implemented.

  Consider doing a re-audit as your audit. This will save all the planning and thinking and show that you understand the process. Even better, start with a re-audit (doing just five sets of notes), make changes to the system as needed and audit again with another five case records.

- ***What your role was*** (i.e. initiated, devised a pro forma, collected the data, analysed, discussed with senior colleagues, identified ideas for change, wrote report, presented to local team/audit meeting).

- ***Presentation/Publication.*** If the audit was presented outside the local environment, or even published either as such or as an abstract, make sure that you mention it.

Choosing an "interesting" audit

The question uses the word "interesting". However, it is possible that the audit which you personally enjoyed the most is not the audit which will help you score the most points.

Your main criterion for the choice of an example should be the extent of your involvement in the project and the strength/complexity of the audit, as these are the factors that will influence the marking the most.

If you can, focus on an audit which is relevant to the specialty to which you are applying. Not only might some marks be allocated for the relevance of the example to the specialty, but, even if this is not the case, the interviewers will be naturally drawn towards an example which they can relate to. Of course, if you find that you have no specialty-related audits which are of any interest but that another audit would make a far more powerful answer then use the latter.

Concluding your answer

The use of the word "interesting" in the question means that you really ought to explain why you feel that the particular audit you have just described is "interesting". It could be because of the topic itself, or because of the potential for change that it offered. It may also be because it gave you an opportunity to develop new skills such as delegation and management, and perhaps IT too. Whatever your reasons, make sure that you explain them (albeit succinctly).

You may also emphasise how much this experience taught you about the audit process and how it gave you an impetus to become involved in other audit projects. You can then name a project in which you are currently involved (name, not describe, otherwise it will take too long).

7.5 What are the problems associated with the audit process?

To answer this question well, you may wish to distinguish between problems associated with audits generally and problems associated with audits carried out by junior doctors (in fact, some LETBs ask about the problems associated with junior doctors' audits).

If you have done one or more audits yourself, you must have identified at least one or two of the problems listed below. In delivering your answer, feel free to use your own audit experience to illustrate your answer in order to give it a more personal, less didactic, slant.

Problems associated with audit generally

- Audits are most often a local process. Though they are useful at improving local practice, they may not be so transferable to other Trusts or units. Other Trusts may not be able to replicate the same approach and, if similar problems are identified, the resolution methods which worked well in one Trust may not achieve the same results when applied in a different Trust.

- Audits are often based on retrospective data (usually patient notes). The data available in the notes was not collected for the specific purpose of the audit. Therefore there may be discrepancies in the way it was recorded and, in some cases, the data may be missing.

- Audits identify that there is a problem or a lack of compliance with a given standard; identifying a solution to the problem identified may not be so easy. Further studies may be required, which can be lengthy.

- Although there are audit departments in most Trusts, those who actually carry out the audits are most often the clinicians, who have many other responsibilities and therefore may not focus entirely on the process. They are also often inexperienced in that activity. This may lead to delay in the implementation of change.

- Unless there is a strong departmental policy of rationalisation of the audit process, topics are not always chosen in the order of priority. This may mean that important areas are neglected, whilst clinicians take on audits which are affordable in terms of resources and are less time-consuming.

The following two points are problems associated with the consequences of the audit process (though not specifically about the audit process itself):

- Audits may identify that non-compliance is linked with the under-performance of specific members of the team or the criticism of certain practices. This makes audit a useful tool, but may also lead to the demotivation of parts of the team if some people feel more targeted than others.

- One of the outcomes of audit is the implementation of change in order to improve standards of care. This change may lead to resistance from some members of the team.

These problems are particularly acute when audits are conducted across boundaries, e.g. the transfer of patients, post cardiac surgery, from the intensive care unit back to the ward. It is easy to criticise another team (e.g. their discharge summaries), but is difficult to change and can in fact inflame the situation. The way to overcome this is to jointly audit the patient's pathway and keep the focus on what is best for the patient.

Problems associated with audits being carried out by junior doctors

- Junior doctors rotate frequently and, if they are around long enough to carry out an audit, they are most likely to leave before a re-audit can be performed. From their own perspective, they are unable to see the impact of the changes that they have helped introduce. From the departmental perspective, it may be more difficult to find someone to do the re-audit (less glamorous, and they would not benefit from the input of the junior who originally carried out the audit).

- In some cases, the audit analysis is either not completed or the recommendations are not taken to implementation stage, thus defeating the whole purpose of the exercise.

- Junior doctors may not command the respect that seniors would have. They may find it more difficult to obtain data or gain support for their audit project.

- Junior doctors tend to choose audit topics which are easier and take shorter periods of time. These topics may not be aligned with departmental strategy or may not be of great importance in the overall scale of things (i.e. the audit is a box-ticking exercise to look good on the CV).

7.6 What is the difference between audit and research?

This is a question that most candidates have heard about and the interviewers know it. There is therefore no excuse for being unprepared. If you have been involved in audit and research activities then you will be able to draw upon your experience to illustrate your answers.

The fundamental difference

The term "audit" is often confused by clinicians, who describe as "audits" projects that are actually research projects. This is fairly common on CVs and application forms, which is why they are keen to test your understanding at the interview. Your application form and CV will be reviewed at the portfolio station. There is nothing more embarrassing than to describe perfectly the difference between audit and research, only to discover that your own documents contradict your words.

Audit is a process which compares clinical practice against set standards, i.e. you are simply trying to determine whether your practice matches the level of care expected of you. Are you following the established guidelines or your own guidelines? Are you aligned with best practice? How much variability is there within your care processes? Are you a learning organisation? Are you doing what you think you are doing?

Research does not check whether you are complying with standards. Instead, its aim is to create new knowledge that can then be used to develop new standards of care. Research determines whether new treatments work and to what extent they do. It is also used to determine which treatments are better than others so that appropriate recommendations can be made.

So, essentially, research helps establish best practice whilst audit checks that best practice is being applied in practice.

Examples

If you are trying to establish
- whether x, y and z are correctly recorded in patients' notes; or
- whether test X is being offered to a specific type of patients, or;
- that the complication rate for a specific procedure is less or equal to the percentage specified in the XYZ Association guidelines,

then this is an audit because you are trying to establish that your current practice is in line with what would be expected.

If, on the other hand, you are trying to establish
- whether procedure A gives better outcomes than procedure B; or
- whether sending patients advance information improves the take-up rate of a specific procedure; or
- whether systematic hand washing decreases infection rate,

then it is research, because you are trying to discover new information, which may then be used to implement new guidelines.

Other differences

- Research is based on a hypothesis, whereas audit measures compliance against standards.
- Research is theory-driven and a one-off process. Audit is practice-driven and a continuous process.
- Results from research can be generalised. Audit results are mostly relevant locally.
- Research is not always conducted by those involved in service provision. Audits most often are.
- Research may involve experimentation, whereas audits never involve experimentation. Audits are mostly a data-gathering exercise.
- Research may involve trying out new treatments, whereas audits never involve new treatments or interference with the management of the patient.
- Research involves strict selection of candidates, allocating these candidates between different treatment groups and validating sample size. In audit, the sample of patients used is not put together scientifically, sample size is not validated and patients are never placed into different treatment groups.
- Research requires ethical approval. Audits rarely do (ethical issues in audit mainly revolve around confidentiality or collection of that data).

Many audits morph into pseudo-research where lots of data is collected and a new pro forma is designed, but in such cases there is no gold standard, no change to the service and often no uptake or spread within the department (particularly after the enthusiast has left).

7.7 Tell us about your research experience.

This question can be asked in all specialties and at all grades, even at grades where many candidates are unlikely to have had any substantial involvement in research. There are easy ways to score points, even if your experience is limited.

The boxes you need to tick

Though the question asks for your experience and nothing more specific, most marking schedules will in fact include much more than that. In order to provide an answer which is as complete as possible, you will need to address the following points:

- The number, type and quality of research projects undertaken.
- The outcomes of projects, including publications and presentations.
- Your role, including any experience of recruiting patients, seeking ethical approval or grant applications.
- Research-related skills that you gained from your experience, e.g. literature review, critical appraisal, statistics and general understanding of research principles.
- General skills gained from your experience, e.g. writing skills, negotiation, communication, teamwork, planning, time management, etc.
- Any relevant courses attended such as research methodology, critical appraisal or statistics courses.
- Your future plans with regard to research.

Answering the question

- ***If you have substantial research experience,*** you will not have the time to describe all of it. You should aim to summarise the extent of your experience first "I have been involved in four research projects including one randomised controlled trial, two studies and one national trial over the past four years as part of the PhD that I am currently completing". You could then summarise one or two of your projects (those you are most proud of) before discussing the extent of your publications and presentations. End the answer by mentioning the courses that you attended and discussing your future research aims and interests.

- ***If you have been involved in a small number of research projects***, describe each project briefly, setting out your role, the courses you attended, the publications and presentations which originated from your experience and the skills that you gained, as well as your future research aims and interests.

- ***If you have no research experience at all***, think carefully first about any project in which you have been involved and which is not an audit. Can this project be considered research, even if it was informal? If yes, then you can present whatever you did in line with the principles explained so far. If not, then don't panic. Many people will be in your situation and you can still score marks by mentioning some of the following:

    - Literature reviews undertaken (which gave you an insight into research principles)

    - Case reports published. Strictly-speaking, case reports do not constitute research because they are simply reporting how a specific patient presented or was managed. However, by sharing your experience with others, you are helping them change or improve their practice. Other benefits include the literature search you will have completed, the rigour of having to write concisely and the overall experience of how to construct a paper and bibliography. Case reports are part of the pool of evidence used in evidence-based medicine and therefore they are relevant to the "spirit" of the question. Some marking schemes make specific allowance for case reports, so make sure you mention yours

    - Attendance at journal clubs (which will have given you critical appraisal skills and an understanding of the research process)

- Attendance at conferences (where you have gained an appreciation of research methodologies)

- Research-related courses.

7.8 Do you think all trainees should do research?

Interpreting the question

This question is often misunderstood. Many candidates say, "Yes everyone should do research because research is important". There is no doubt that research is important but it does not mean that everyone has to be involved in it. In popular specialties, research is often done to develop a competitive advantage over peers. This is again a poor reason for doing it.

With this question, the interviewers are testing:
- Your understanding of the pros and cons of undertaking research at a junior level
- Your appreciation of the importance of research to a junior doctor (which we have addressed in 9.17).

Key points:

- If "research" means time out being taken to undertake a PhD, MD, MPhil, or other degree, then it is probably not necessary for all trainees to become involved. The reasons for this are that:

  - A lot of research achieves little and/or does not get published.
  - Many research projects do not get completed through lack of time or lack of funding.
  - The limited funding and resources are best saved for those with real enthusiasm or ability.
  - Some trainees may not particularly like research. Making such a big commitment might demotivate them and be counterproductive.
  - Taking time out to do research means moving away from clinical duties and therefore creating greater difficulties in continuing clinical training. If the research period is too great, there is a danger of deskilling.
  - Formal research is probably best left to those who enjoy it and feel that they can fruitfully contribute. In fact MMC recognises this by creating special academic posts for those who want to develop a research interest. The system therefore recognises that not everyone needs to have a formal research interest.

- Even if they are not formally involved in research, trainees need to understand the principles of research in order to be safe and effective clinicians. In the context of evidence-based practice, trainees will need to understand how research is conducted, and what makes bad and good research. They will need to be able to critically analyse papers in order to determine their validity and how the findings can be interpreted to help clinical decision makings (for more details, see 9.17 – paragraph on the importance of research to junior doctors). Although first-hand research experience would be useful to gain such understanding, it can also be gained through other means, such as:

  - Attending journal clubs
  - Attending conferences and relevant courses (statistics, critical appraisal, research methodologies)
  - Getting involved in smaller, ad hoc or informal research projects (e.g. one afternoon per week), which will not distract from clinical training
  - Doing literature searches, for example to set a standard for an audit or as part of evidence-based practice.

Answering the question

In answering this question, it is important that you debate the issue rather than rush into giving a strong opinion. There is no harm at all in having a strong opinion, but you need to ensure that it is put

into perspective. You should demonstrate your understanding of research, its importance to clinicians and the issues raised by introducing research in the training curriculum.

If you have any meaningful experience of research, then make sure that you talk about it in your answer. Rather than discussing the usefulness of research to a trainee from a general perspective, you will gain marks for relating your arguments to your own experience (i.e. discussing how you benefited from your own research experience).

Similarly, if you have little research experience, but feel that you have gained appropriate competencies through other means, then you should state this, confidently.

Your experience is more valuable than any general statement.

7.9 What is Evidence-Based Medicine?

Definition of evidence-based medicine

Evidence-based medicine (EBM) has been defined as "the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients. The practice of evidence-based medicine means integrating individual clinical expertise with the best available external clinical evidence from systematic research." (David Sackett et al., *Evidence Based Medicine: What It Is and What It Isn't*, BMJ 312, no.7023 (1996))

In 2000, David Sackett revised his definition as follows: "integration of best research evidence with clinical expertise and patient values." David Sackett et al., *Evidence-Based Medicine: How to Practice and Teach EBM* (New York: Churchill Livingstone, 2000), 1

The steps involved in evidence-based medicine

- A question arises regarding the care of a particular patient.
- The physician constructs a well-defined clinical question from the case in order to resolve the problem.
- For treatments, the PICO formula can be used to make Medline searches more specific (Population, Intervention, Comparison and Outcome).
- The physician conducts a search of the existing literature by using the most appropriate resources.
- The evidence is then appraised for its validity and applicability. The physician then determines the best available evidence.
- The physician integrates the evidence with his clinical practice and the patient's preferences to find a practical solution to the original problem.
- The result is then evaluated with the patient.

Answering the question

Step 1: Define briefly what evidence-based medicine is

You should be wary of using ready-made definitions (the same applies to the classic definition of clinical governance) as they simply demonstrate your ability to regurgitate ready-made answers and do not highlight any personal understanding of the underlying issues.

The above definitions also use words that are unfamiliar to many people and which are best avoided (for example, people may not know that "judicious" means "based on sound judgement").

Try to build your own practical definition, showing that you have a good understanding of what EBM entails. EBM is essentially a combination of the best available research evidence with your own clinical expertise and judgement. This is then applied to a specific case, taking into account patient values.

Step 2: Explain the different steps involved

Step 3: If you have one, give a brief example of a situation where you used evidence-based medicine

This might include:

- Having had to deal with a patient for whom normal guidelines did not fit.
- A situation where the existing guidelines were out of date and where you needed to derive your own approach using more recent evidence.
- A situation where national guidelines were not suitable for the local pattern of disease.
- Situations where there are new, controversial treatments which are not yet in routine practice. You would then evaluate the evidence with your colleagues to devise a local strategy.
- Situations where a patient may have read about a drug in the press and may have a particular interpretation. You would need to review the evidence before presenting your personal or departmental perspective.
- Situations where you have to guide the patient to make an informed decision. This would involve presenting the relevant evidence and the efficacy, benefits and risks of the different options according to the literature.

7.10 What are the different levels of evidence?

There are three different ways to describe the levels of evidence. The easiest classification system is:

Level	Description
Ia	Systematic review or meta-analysis of randomised controlled trials
Ib	At least one randomised controlled trial
IIa	At least one well-designed controlled study without randomisation
IIb	At least one well-designed quasi-experimental study, such as a cohort study
III	Well-designed non-experimental descriptive studies, such as comparative studies, correlation studies, case–control studies and case series
IV	Expert committee reports, opinions and/or clinical experience of respected authorities

Many candidates have learnt the above table and know it well (particularly in surgery). I would therefore encourage you to try to remember it if you can. If you struggle to remember this, particularly at interview, don't panic. It is important you remain confident and explain what you can.

A simple answer such as: "I cannot remember the exact detail of each level; however, I do know that the different levels of evidence range from the strongest level which is a systematic review all the way to the weakest which is represented by the opinion of experts", may not sound much but it is better than waffling desperately through a confused list.

7.11 What is clinical governance?

A well-known definition that you should avoid

The most widely used definition of clinical governance is as follows:

> "A framework through which NHS organisations are accountable for continually improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish."
>
> G Scally and L J Donaldson, *Clinical governance and the drive for quality improvement in the new NHS in England,* BMJ (4 July 1998): 61-65

Although you should of course familiarise yourself with this definition, there is no need to memorise it. Under pressure, most candidates remember the beginning and the end, and mess up the middle part. Even if you remembered it perfectly, you would only demonstrate that you have a good memory and not that you understand the concept.

Instead, you should derive your own practical and down-to-earth definition.

How can you define clinical governance?

Anything which avoids the word "flourish" and can be delivered in your own natural words will do, providing it addresses the concepts of quality and accountability. Here are a few examples:

> Clinical governance is a quality assurance process, designed to ensure that standards of care are maintained and improved and that the NHS is accountable to the public.

> Clinical governance is an umbrella term that encompasses a range of activities in which clinicians should become involved in order to maintain and improve the quality of the care they provide to patients and to ensure full accountability of the system to patients.

The 7 pillars of clinical governance

Traditionally, clinical governance has been described using 7 key pillars. Although it has been refined over the past few years, this approach remains the easiest to remember and to describe at a trainee interview level. It is also the approach that your interviewers are most likely to expect from you since this is what they would have learnt too. The 7 pillars are as follows:

Clinical Effectiveness & Research
Clinical effectiveness means ensuring that everything you do is designed to provide the best outcomes for patients, i.e. that you do "the right thing to the right person at the right time in the right place". In practice, it means:

- Adopting an evidence-based approach in the management of patients
- Changing your practice: developing new protocols or guidelines based on experience and evidence if current practice is shown to be inadequate
- Implementing NICE guidelines, National Service Frameworks and other national standards to ensure optimal care (when they are not superseded by more recent and more effective treatments)
- Conducting research to develop the body of evidence available and therefore enhancing the level of care provided to patients in future.

Audit
See 7.3 for full details on clinical audit. The aim of the audit process is to ensure that clinical practice is continuously monitored and that deficiencies in relation to set standards of care are remedied.

Risk Management
Risk Management involves having robust systems in place to understand, monitor and minimise the risks to patients and staff and to learn from mistakes and near misses. When things go wrong in the

delivery of care, doctors and other clinical staff should feel safe admitting it and be able to learn and share what they have learnt. This includes:

- Complying with protocols (hand washing, discarding sharps, identifying patients correctly, etc.)
- Learning from mistakes and near misses (informally for small issues, formally for the bigger events – see next point)
- Reporting any significant adverse events via critical incident forms, looking closely at complaints, etc.
- Assessing the risks identified by likelihood of recurrence and the severity of impact if an incident did occur. Implementing processes to reduce the risk and its impact (the level of implementation will often depend on the budget available and the seriousness of the risk)
- Promoting a blame-free culture to encourage everyone to report problems and mistakes.

Education & Training

50% of medical knowledge changes every 5 years and so education and training are essential for clinicians to keep up to date. Further, professional development needs to be driven by self-directed life-long learning. In practice, for doctors this involves:

- Attending courses and conferences (commonly referred to as CPD – Continuous Professional Development)
- Taking relevant exams
- Regular workplace-based assessment, designed to ensure that doctors have the appropriate competencies
- Appraisals (which are a means of identifying and discussing weaknesses, and opportunities for personal development).

Patient and Public Involvement (PPI)

PPI ensures that the services provided are effective, that improvements are made from the patient's perspective, and that patients and the public are involved in the development of services and the monitoring of treatment outcomes. This is being implemented through a number of initiatives and organisations, including:

- Local patient feedback questionnaires
- The Patient Advice and Liaison Service (PALS): resolves patient concerns
- National patient surveys organised by the Healthcare Commission, which then feed into Trusts' rankings
- Local Involvement Networks (LINks), which have been introduced to enable communities to influence healthcare services at a local level (these used to be called "Patient forums")
- The Foundation Trust Board of Governors, elected by members of the local community. It has a say on who runs a hospital and how it should be run, including the services it can provide.

Using Information & IT

This aspect of clinical governance ensures that:

- Patient data is accurate and up to date
- Confidentiality of patient data is respected
- Data is increasingly used to measure the quality of outcomes (e.g. through audits) and to develop services tailored to local needs.

Staffing & Staff Management

This relates to the need for

- appropriate recruitment and management of staff,
- ensuring that underperformance is identified and addressed,
- encouraging staff retention by motivating and developing staff and
- providing good working conditions.

From the above explanations, you may have noted that some of the pillars are more directly related to the day-to-day responsibilities of a junior doctor:

- **C**linical Effectiveness
- **A**udit
- **R**isk Management
- **E**ducation & Training

Whenever you discuss clinical governance in an answer, you may prefer to discuss these in more depth and simply mention the other three. You can remember these 4 key pillars with the mnemonic CARE.

Mnemonics

If you are the type of person who likes to remember information through the use of mnemonics, here are a couple which will enable you to remember all the components of clinical governance:

Patient & Public Involvement
Information & IT
Risk Management
Audit
Training / Education
Effectiveness (Clinical)
Staff management

Staff management
Patient & Public Involvement
Audit & IT
Risk Management
Effectiveness (Clinical)
Information & IT
Training / Education

Answering the question

When asked to talk generically about clinical governance, a good structure for your answer would be as follows:

- Brief definition of clinical governance in your own words
- State and define the four CARE pillars
- List the other three pillars (with brief explanations if you have time)
- Give brief examples where you have practised clinical governance

Alternatively, you could bring examples within each of the four CARE pillars instead of bringing them in at the end of the answer. Whatever you do, do not attempt to describe each of the pillars in detail. Discussing an introduction to clinical governance and 7 pillars in two minutes would allocate only 15 seconds per section. Not only are you unlikely to remember everything in the right order, but you will also find yourself speeding through your answer. It is better to talk knowledgeably and confidently about 4 pillars than to waffle about all 7.

7.12 What is your experience of clinical governance?

Be careful with questions on clinical governance because it is easy to regurgitate its definition and the 7 pillars without really answering the question. This question does not ask for a description of clinical governance, but for your own experience of it. The examiners will judge you on your overall understanding of governance, and the relevance and clarity of your examples. In order to achieve this, you must choose the pillars which are the most relevant for you, i.e. those which you are most likely to have had experience of. These would typically be the CARE pillars (see previous question).

Here are some questions which will help you think about your experience in each area of clinical governance:

Clinical Effectiveness
Have you:
- Played a role in implementing new guidelines or protocols in your department?
- Played a role in facilitating the use of guidelines in your department, for example by creating proformas or checklists?
- Initiated a change to an established protocol because you felt that it was inappropriate?
- Collated a set of guidelines (whether in hard copy or online)?
- Needed to do a literature search or read up on guidelines to determine the best care for a patient?
- Got any research experience?
- Published case reports or papers?

Audit
Have you:
- Participated in an audit?
- Had opportunities to improve clinical practice with one of your audits?
- Supervised others doing audits?
- Completed an audit, including making changes and re-auditing?

Risk Management
Do you:
- Double-check that you are doing the right thing (labels, dosages, etc.)?
- Seek help or advice from others appropriately?
- Encourage your juniors to come to see you if they have problems or if they have made mistakes?
- Show support towards juniors (rather than blame them) when they get things wrong? When this happens, do you consider how the system can be improved to ensure that mistakes do not happen again?
- Know what Root Cause Analysis is? This is a thorough investigation into the background surrounding a serious untoward event (critical incident), examining protocols, actions, personnel. One technique is the Five Whys: Why did that happen? And why did that happen? Etc.

Have you:
- Identified a problem with some aspects of care in your team and raised the issue with seniors (i.e. a protocol out of date, a common practice which is not wholly appropriate)?
- Reported any significant issues or near misses?
- Made a mistake or had a near miss that you then reported and discussed with colleagues (or maybe formally recorded through a critical incident form)?
- Dealt with a patient's complaint and ensured that practice changed as a result?

Education & Training
Do you:
- Have a personal development plan?
- Attend courses on a regular basis?
- Identify your weak areas and find ways of improving your skills?
- Read about cases you have seen, when you get back from work?
- Observe senior colleagues to learn from their practice?
- Ensure that you teach and train junior colleagues when the opportunity arises (and take the initiative to do so without being asked)?
- Read journals regularly?

Patient / Public involvement
Have you:
- Done an audit of patient satisfaction?
- Designed a questionnaire to obtain patient feedback?
- Sought informal feedback from patients on your/your department's performance?
- Been involved in responding to patient concerns about your service?
- Involved patients in the design of either a service or some teaching?

Using Information & IT
Do you:
- Anonymise data when you use it for audit or other purposes?

- Correct patient records when they are found to be inaccurate?

Have you:
- Queried data to identify trends and subsequently suggested changes to practice (maybe as part of an audit project)?
- Gained IT skills relating to data handling (e.g. databases, web)?

Staffing & Staff Management
Have you:
- Had to discuss performance issues with a colleague or had to report underperformance to senior colleagues?
- Taken steps to improve working relationships within a team in which you worked?
- Developed ways of improving relationships with other teams (e,g. nurses, other departments)?
- Made efforts to involve others in projects, when you felt they would benefit from such an involvement?

Delivering your answer

Once you have identified the extent of your experience, all you need to do is list each of your experiences using the pillars as your structure. For each experience, explain how this contributed towards governance and helped maintain or improve standards of care.

8 Difficult colleagues

What are the interviewers testing?

The interviewers will use these questions to test a range of skills and behaviours, including:

- Being safe: patients should be your first priority and the interviewers will want to know that you are not placing yourself or your colleagues before patient safety.

- Your understanding of the dilemmas that the situation presents. These questions are difficult because there isn't always a single answer. For example, there are rumours about a colleague taking drugs in his spare time. You could argue that it is none of your business, but it may develop into something more serious and place patients at risk. You will need to demonstrate that you understand the different perspectives and that you are able to decide on an appropriate course of action.

- Your approach to the problem: many candidates think that telling the clinical director will resolve the problem. There are often times, however, when the problem can be resolved without going to senior colleagues (e.g. if the subject has only been late a couple of times). In any case, seniors will generally prefer you to "bring solutions, rather than problems". There are times where it is necessary to involve a senior colleague and this should be handled sensitively. The interviewers will be looking at the thought processes that you demonstrate.

- Your communication skills and empathy: some scenarios may contain a more human element, i.e. where the behaviour exhibited by the colleague is potentially linked to a personal problem. In other scenarios, the situation could be very delicate and seriously backfire if communication is not handled properly. The interviewers will be keen to know that you can handle these matters sensibly and communicate appropriately.

- Your team approach: it is unlikely that you will be able to sort out the problem by yourself. The interviewers will therefore want to determine to what extent you involve other people from the team, and how appropriate that involvement is.

Answering the question

Questions on problem colleagues may look different on the surface but once you have learnt to answer a few of them you will know how to approach pretty much any scenario thrown at you. In order to make best use of the material contained in this chapter, it is important that you familiarise yourself with the SPIES structure. It will form the backbone of your answer. In order to provide an effective answer, you will also need to follows the following principles:

Avoid providing answers that are too robotic and algorithmic
Although ready-made structures are extremely useful to ensure that you don't forget any salient points, it is also crucial that you use your common sense whenever you answer any question relating to practical situations. You do not handle a drunken consultant in the same way that you would handle a junior colleague who is often late. Keep things in perspective and use your common sense.

Explain the "how" and the "why", not just the "what"
Most candidates "know" the answers to all these "difficult colleague" questions. However, not many deliver answers which are interesting to listen to. After 15 candidates, the interviewers will be bored of hearing the same thing time after time. In order to provide an answer which is different and highlights your maturity, you will need to mention all the essential steps and why you would act that way.

For example, you may feel that the situation needs to be escalated to the clinical director. Why is that and how would you handle that process?

- Will you discuss the matter with the problem doctor first or not? If not, why not? And if yes, what will you be achieving by doing this?

- Is the clinical director the best person to contact? What about the colleague's educational supervisor or another consultant? Which is better and why?

- Will you actually be formally discussing the matter with a senior colleague or will you simply raise it informally with them? Why? What are you seeking to achieve?

- You will no doubt need to demonstrate that you can support the colleague in question as well as your team in dealing with the problem. How will you do that and why?

My experience is that candidates take an approach that is far too theoretical when they answer questions on difficult colleagues. To ensure that your answer is natural, try to imagine what you would do if this were a real situation. In other words, stop thinking of the question as an "interview" question and start picturing yourself in a real-life scenario. Use your common sense.

If possible, highlight the dilemmas at the start of your answer

Once you have been given a scenario, you should be able to determine very quickly what problems the situation poses. If possible, you should present these at the very start of the answer so that your interviewers know how you are approaching the problem.

For example, if you have to deal with the "drunk consultant" question, you could start your answer with a statement such as "There are two problems that this scenario poses. I will need to make sure that patients are safe but I also need to make sure that the problem is handled sensitively so that the consultant does not suffer any more embarrassment than he has already caused."

This will give an idea of the direction that you are taking and will also reassure the interviewers that you are thinking rationally about the problem rather than just regurgitating some standard answer.

Avoid providing specific examples in the main body of the answer

Some of you may have had experience of dealing with problems similar to the scenario that the question is addressing. If this is the case, do not mention them before you have dealt with the generality of the question. If you go straight into a specific example, you will spend all your time on it and will miss out some vital parts of the answer, which may not have featured prominently in the real-life situation that you dealt with.

8.1 One of your consultants comes on the ward drunk one morning. What do you do?

What you are trying to achieve?

Your main objectives in dealing with this situation will be to ensure that:

- patient safety is assured
- the consultant is safe
- seniors are aware so that action can be taken to prevent the problem from recurring and to ensure that the issues which led the consultant to become drunk are being addressed
- the consultant is supported in dealing with these issues
- the whole situation is handled sensitively.

Applying the SPIES structure

Seek information
There is little information you need to gather if you are actually present when the consultant comes in. The question is telling you that he is drunk so there is no information you can gather which would make a difference to the way in which you handle the matter. The outcome of the investigation may, however, be altered if he has been affected temporarily by a divorce or bereavement.

Patient safety.
If the consultant is drunk then he is a danger to patients and should be taken away from the clinical environment. In this case the clinical area is the ward, but the question could equally refer to a theatre.

There are many ways in which you could remove the consultant from the clinical area but, however you do it, you must make sure that you do it in the quickest and most sensitive manner so as to minimise the impact on patients and the embarrassment to the consultant and to the team.

You may want to try the following approaches (in decreasing order of suitability):

- Talk to the consultant and convince him to leave and go home
- Involve another senior member of the team (another consultant or even a senior nurse) who may have more influence than you on the consultant. Remember that you are trying to handle the matter sensitively, therefore you would need to involve someone that the consultant trusts in order to minimise conflict.
- A senior member of an adjacent team. Typically this would be another consultant.
- Security (as a very last resort – hopefully you will have found someone to help you before you reach this stage).

Once the consultant has left the clinical area, you will need to make sure that any actions or decisions made by that consultant are reviewed and that any patients he has seen are followed up appropriately.

Initiative
Is there any action that you could undertake by yourself (i.e. before you involve anyone else) to resolve or help the situation at your level? In the case of a drunken consultant, it would be inappropriate for you to attempt to resolve the entire problem by yourself; however, there are a number of useful steps that you can take such as:

- Making sure that the consultant is safe, i.e. that he goes home safely by taxi or sleeps it off in the doctors' mess. Make sure that he doesn't drive home and check that he has arrived safely.

- Informing the person in charge that the consultant was unwell and needed to go home so that appropriate cover can be arranged.

- Volunteering to cover some of consultant's duties, which might otherwise be neglected. At a junior level, you might not be able to take on the responsibilities that the consultant would have handled, but you can work with the team to share the workload and ensure that patient care is being appropriately provided.

Escalate
If the consultant turns up drunk, then there is no doubt that this shows a lack of insight – despite being drunk, he failed to realise that he could constitute a danger to patients. His judgement is questionable and he therefore poses a risk to patients, not only in the present, but also in future if he has or develops an alcohol addiction.

As a result, you would be expected to raise the matter with an appropriate senior colleague. You would want to avoid contacting too many people so as not to spread rumours and undermine the reputation of the problem consultant. You really need to contact someone who is likely to have some influence over the situation; this would typically be the clinical director or a senior consultant who can take the problem on board and start dealing with it.

From then on, you have effectively transferred the responsibility of dealing with the problem to senior colleagues. However, although this probably means that your input will no longer be required to deal with the core of the matter, you still have a responsibility to raise the alarm if you feel that the senior response is inadequate.

Support
The consultant's behaviour is likely to have its roots in some kind of personal problem. In addition, the incident is likely to have consequences, if not for his career, at least on his credibility. You should therefore show as much support as you can towards him (more so if you know him well). You should

also ensure that you support your team in dealing with consequences of the problem; for example you may need to take on extra duties temporarily until the consultant gets better.

Follow-up questions

Interviewers often ask follow-up questions to test your understanding of your responsibilities and duties as a doctor. Follow-up questions typically include:

- "Once you have reported the problem to the clinical director, what is likely to happen?")
- "What would you do if the drunken consultant asks you not to mention anything to anyone, because it was the first time that it happened and he promises it won't happen again?"
- "If, after reporting the matter to the clinical director, you find that he is not responding appropriately, what would you do?"

8.2 One of your junior colleagues has been late for 20 minutes every day for the past 4 days. What do you do?

This is another question about a problem colleague, and therefore we suggest using the SPIES structure.

Seek information
There may be different reasons why the colleague is late. Maybe he has discussed this with a senior colleague previously but simply failed to inform you about it. Maybe he is having personal problems which he does not wish to share with others. Maybe his train is late due to engineering works. Maybe he is new to the hospital and is travelling long distances. Or maybe he has an attitude problem.

With a lot of "maybes", you really need to seek some information about the nature of the problem. This can be done by approaching the colleague and gently asking whether there is anything you can help with. You can add that you have noticed he has had trouble getting to work on time.

Patient safety
A delay of 20 minutes is unlikely to cause major concern towards patient safety. In most cases, it will have an impact on the team without necessarily impacting on safety. However, there may be cause for concern if:

- the colleague is missing handovers and provides substandard care
- the colleague is carrying the crash bleep and is not always available
- the colleague rushes jobs to make up for his lateness.

If this is the case, then you should raise these concerns with a clinic or ward manager or any senior colleague so that they can take action. You should also ensure that patient safety is not affected. This may mean ensuring that you take on some of his jobs or place at handovers.

Initiative
It is possible that the problem is due to a temporary problem such as family problems or train delays. If the problem is likely to be very short term and you are reassured that your colleague has tried his best to sort things out, then you may wish to show a little flexibility by covering for him for the period of the delay and also by recommending that he should discuss his problems with a senior colleague or a manager so that they can arrange a more flexible working pattern temporarily. Whatever you agree with your colleague should be shared with someone more senior. The manager may suggest a contract which makes expectations transparent for both parties.

Escalate
If you feel that the problem is affecting patient safety, that there is a lack of insight or that it is likely to persist, you will need to involve a consultant more formally.

Support
If the issue is linked to a family problem, then your colleague will appreciate your personal support during this difficult period.

The answer to this question requires more consideration than for the underperforming colleague. Due to the strong likelihood that the delay is linked to personal issues, your answer should reflect this by placing an equal emphasis on flexibility and support, and on raising the matter with senior colleagues.

8.3 Your consultant is managing a patient against the recommendations of the established guidelines. What do you do?

This question looks like a question on a difficult consultant but combines it with your knowledge of evidence-based practice and more specifically your understanding of the definition of a "guideline"

Seek information
Before you jump to conclusions, you need to understand why the consultant is making the decision to go against the guideline. After all, he has several more years' experience and his decision is most likely to be correct.

The process of evidence-based medicine combines many more aspects than just the guideline. In particular the consultant's clinical judgement and the patient's values have to be taken into account. Consequently there are many reasons why the consultant may have taken his decision. For example:

- The guideline may not be suitable for the patient
- The consultant may be aware of recent evidence which would supersede the guideline (though the guideline has not yet been changed to allow for that evidence)
- The guideline may be suitable but the patient may have refused the recommended treatment.

Whatever the situation, the consultant should be in a position to educate you about his decision. The easiest way to approach him without sounding confrontational is to raise with him the fact that you are struggling to understand the decision that is being made and would like to discuss it with the consultant from an educational perspective.

Hopefully, by that time, you will be reassured that he is making the right decision.

Ensure patient safety at all costs. Escalate if necessary
If, after obtaining further information from the consultant, you feel uncomfortable about the proposed management then you must raise your concerns: in the first instance with the consultant, and, if needed, with another consultant. If you cannot get hold of another consultant, talk to the clinical director or another colleague.

Don't forget that you could also be wrong. So, if you have doubts, you always have the opportunity to discuss the issue with colleagues at your level or look things up. Also, remember not to contradict the consultant in front of patients. Any disagreement should be raised away from patients.

If the situation is an emergency and you do not have time to ask for a second opinion or engage in a discussion, then you will have no choice but to let the consultant go with his decision but you must record your disagreement in writing in the patient notes. This way, if there is a problem, you will not be blamed for not trying to resolve the initial problem.

Learn from the situation
If the consultant ended up being correct then you must ensure that you take steps to learn from that situation. You might want to read up on related matters or discuss the case at a teaching session.

8.4 Your consultant has made a mistake as a result of an error of judgement and is asking you to alter the patient's notes to match his version of events. What do you do?

There is no possible motive that could justify the consultant's behaviour. By not reporting the matter, you would not only help the consultant cover up for his mistake but you would also expose other patients to harm by not ensuring that action is taken against the consultant.

Seek information
There is no information to gather here as the nature of the problem is obvious.

Patient safety
Ensure that whatever mistake has been committed has been resolved and that the patient is safe (if the mistake did not result in death).

Initiative
Refuse to comply with the consultant's request and explain that it is unethical. You should also make a written record of the conversation that you are having with the consultant as your testimony may be required if any further action is taken.

Escalate
This issue is too serious for you to handle on your own. The consultant's behaviour is placing patients at risk and poses questions about his integrity. You should report the matter to the clinical director at the first opportunity. If he is not available or refuses to deal with the issue, escalate the matter to the medical director and thereafter to the chief executive.

Support
There is no support to give here, other than maybe towards the team in dealing with a situation where a consultant has gone (since he will most likely be suspended if your claims prove true).

8.5 During a ward round, your consultant shouts at you in front of a patient for getting an answer wrong. What do you do?

This is the type of question where it can be easy to get into automatic mode without thinking about the depth of the question, with an answer such as "This is bullying and therefore I will need to report it".

Yes, technically it is bullying and yes, it is unacceptable. However, your reaction will much depend on who the consultant is, whether he makes a habit of it, or whether it was just a normally pleasant consultant who became irritated on that day because of stress.

In your answer, you will therefore need to ensure that the unacceptability of the event is addressed, but also that you place the whole event into perspective and use your common sense.

Seek information
It is best not to allow the situation to escalate to full conflict, particularly in front of patients. In the first instance, you should simply shut up and arrange to meet the consultant after the ward round so that any discussion can be held in private. This will ensure that patients do not become witnesses to more conflict and also that an adult discussion can take place away from the emotions of the argument that took place in front of others. Once you are with the consultant, you must insist on an explanation for the shouting.

Patient safety
There is no patient "safety" issue as such here, but the patient's confidence in their medical care may have been undermined by the argument that they witnessed. You have also been embarrassed by the incident. In such circumstances, it would be appropriate for the consultant to talk to the patient themselves to apologise and reassure them. If the consultant does not want to do this, then you should take the initiative to do so yourself. If you feel uncomfortable about the whole idea or you feel that you

may make things worse, you always have the option to talk to another consultant about it, who may be able to assist in the process.

Initiative
During the discussion with the consultant, if he has identified areas of concern about your performance, you should ask him how he feels you can resolve this. However, you should also remind him that it is never acceptable to put someone down in public, and even less so in front of patients. If you feel that you cannot do this, perhaps because the consultant is aggressive generally anyway, and that raising the matter directly with him would be counterproductive, then you still have the option of asking another consultant for advice (such as your educational supervisor, or any other consultant).

Escalate
If you feel threatened by the consultant or if this incident has become a bit of a habit, then you have to ensure that you discuss the problem with senior colleagues. In the first instance, the most obvious port of call would be your educational supervisor for advice, but you really ought to go straight to the clinical director as he is the person who is likely to have the most influence on the situation in terms of finding a lasting solution.

If this fails, then you should refer to the section in your employee manual/booklet dealing with bullying. That section will most likely tell you to report the matter in confidence either to the medical director or to someone from HR (each Trust is likely to have its own policy).

However, one thing is for sure: before you escalate the matter outside your team, you must take all possible steps to demonstrate that you have attempted to resolve the problem amicably within your team.

Support
This is not so relevant here. If anything, you are the one who needs to be supported. However, if the shouting was linked to stress or personal problems on the consultant's side then you should show some understanding (which is different to accepting the bullying!).

9 Confidentiality, consent and other ethical principles

Occasionally, you may be asked questions relating to general ethics and its application to concrete scenarios. These questions could relate to issues as varied as difficult patients, complex consent issues or the management of an emergency with which you are unfamiliar.

The range of possible questions has no boundaries and your knowledge of ethics can be tested in different ways:

- By asking you factual questions about a key issue:
  - "What do you understand by the words 'Gillick competence'?"
  - "In which circumstances do you think it is acceptable to breach patient confidentiality?"

- By asking you how you would handle a specific situation, e.g:
  - a 14-year-old girl asking for a termination of pregnancy
  - an epileptic taxi driver who refuses to stop driving
  - an unconscious Jehovah's Witness who requires a blood transfusion.

- By engaging you in role play, with the patient being played by an interviewer or a trained actor.

Whatever the format, it is helpful to remember that all issues relate to four key principles. Therefore, rather than learn the management of individual situations by heart, concentrate on understanding and applying those key principles.

9.1 The four ethical principles of biomedical ethics

The following four principles are those used in biomedical science to guide decisions:

- **Beneficence**
  This word comes from the Latin "Bene" = Good and "Facere" = To do. Essentially it means that you must act in the patient's best interest.

- **Non-maleficence** (also, but rarely, called non-malfeasance)
  From the Latin "Male" = Bad and "Facere" = To do. You must not harm your patients. It is important to remember that many treatments may actually harm the patient (e.g. through side-effects) but what you need to keep in mind is the balance between benefit and harm.

- **Autonomy**
  From the Greek words "Auto" = Self and "Nomos" = Law, Custom.
  The patient has the right to choose what they want (i.e. whether to accept or refuse treatment).

- **Justice**
  Patients must be treated fairly. This principle deals mainly with the distribution of scarce resources and is particularly relevant when dealing with expensive drugs or procedures. It is the principle that may be applied to justify not giving a patient an expensive treatment if it means that a large number of patients then cannot benefit from other treatments as a result. However, in medicine, it is rarely used by doctors as decisions on drug availability are often taken at PCT/SHA level.

Whenever a dilemma occurs, it is because two or more of these principles clash. For example, a Jehovah's Witness refusing a blood transfusion will cause a clash between:

- Beneficence – transfusing is the best option to manage the patient
- Non-Maleficence – not transfusing may result in the patient's death
- Autonomy – the patient can choose what they feel is best for them.

Note: If the patient is competent, Autonomy always prevails over Beneficence and Non-Maleficence, i.e. the patient can do what they want with their body whether you think it will benefit them or harm them.

9.2 Confidentiality

The patient's right to confidentiality

The right to confidentiality is central to the doctor-patient relationship. It creates trust which makes patients feel safe to share information, without fear of that information being used inappropriately.

There are a number of simple measures that you can implement to ensure that patient confidentiality is protected (some of which may be discussed at interviews in specific patient-based scenarios). These include:

- Not leaving computers with patient records unattended
- Not leaving patient details showing on screen where they can be viewed by others
- Not letting patient notes lie around and not taking notes home with you unless they have been anonymised
- Not leaving handover sheets where they can be seen by patients and families
- Ensuring you check the identity of patients, particularly if you are discussing matters over the phone
- If the patient comes accompanied, asking the patient if they are comfortable with a third person sitting in on the consultation
- Not using the public as translators, even if they offer (e.g. unaccompanied, non-English speaker in the Emergency Department). There are a number of commercial interpreters available via telephone (e.g. LanguageLine)
- Carefully considering your reactions to questions asked by relatives or outside organisations (police, social services, etc.) when directed towards you.

Breaching patient confidentiality

Although patient confidentiality should be protected, there may be instances where it needs to be breached, some of which may be relevant to your daily practice.

The situations where breaching confidentiality is appropriate include:

- ***Sharing information with other healthcare professionals or others involved in the care of the patient***
  As a doctor, you constantly breach patient confidentiality by passing on information to other healthcare professionals. This may include sending a discharge summary to the patient's GP, or sending a referral letter to another doctor. It is accepted that such breaches are a routine aspect of patient management, providing the information is restricted to essential information. The patient is deemed to have provided implied consent. However, you must make sure that the patient understands that such disclosure of information is being made and, if the patient objects to the disclosure, you must take every possible step to comply with their wishes.

- ***Using information for the purpose of clinical audit***
  In order for the results of clinical audits to be meaningful, they include a representative sample of the patient cohort. It is therefore in the interest of good quality healthcare for patient data to be used for clinical audit. Providing patients have been informed that their data may be used internally for the purpose of audit and healthcare improvement, and providing they have not objected to its use, then you may use their data for the purpose of audit. This is a form of implied consent since you are not actually asking the patient to agree; you are simply informing them and allowing them to disagree, which rarely happens. If data is being given to external organisations for audit purposes, then the data must be anonymised. The data protection act also governs the way data is stored. Patients need to be informed which personal details are being held for audit or research purposes.

- ***Disclosures required by law***
  There are a number of statutory requirements such as notifying a communicable disease, in accordance with the Public Health (Infectious Diseases) Regulations 1988. This includes measles, meningitis, mumps, tetanus and many others. The full list is available from the Health Protection Agency's website at www.hpa.org.uk. As always, you should make every effort to inform the patient, but their refusal cannot discharge you from your legal obligations.

- ***Court order***
  You must disclose any information requested through a court order.

- ***Disclosures to a statutory regulatory body***
  When investigating the fitness to practise of a health professional, regulatory bodies may require information about specific patient cases. Whenever possible you should discuss the disclosure of the information with the patients concerned. If discussing consent is not practical, or the patient refuses to give consent, then you need to discuss the situation with the regulatory body in question (e.g. GMC). They may judge that the disclosure is justified even without patient consent.

- ***Disclosure in the public interest and to protect the patient or others from risk of serious harm or death***
  There may be cases where the benefit to society far outweighs the harm to the patient caused by the release of information:

  - In extreme cases of HIV patients knowingly infecting others
  - An epileptic driver who continues to drive, despite advice from the DVLA
  - Any case of very serious abuse where the victim is at serious risk of harm or death, even if they are a competent adult
  - Notifying the presence of a sex offender
  - A patient who is a doctor placing patients at risk through a medical condition (e.g. a surgeon with Hepatitis C).

- ***Treatment of children or incompetent adults***
  This may happen when a child comes to see you, is not competent enough to make a decision, but is asking you to keep their visit confidential (the same would apply to any incompetent adult). In the first instance, you will need to negotiate with the patient to convince them to involve an appropriate person. If they refuse, then you may need to involve a third party anyway but only if you consider that the treatment is essential and in the patient's best interest. The patient should be aware of your intentions at all times.

- ***Abuse or neglect of an incompetent person***
  The most common cases would be child or elderly abuse, or abuse of a patient with a mental illness.. If disclosure is in the best interest of the patient then you should do so promptly. If you decide not to report, you should be able to justify your decision. In fact, with child abuse, there is a duty to share information with other agencies, such as social care and the police. Therefore, if you suspect a child is about to make a disclosure, you should inform them that you will keep information confidential, unless they tell you something that you would need to share in order to protect their best interests.

Involving the patient

Whenever you need to breach confidentiality, you should always discuss it with the patient beforehand, obtain their consent and inform them of your plan. Although potentially a difficult conversation, it would certainly be easier than having to explain the breach afterwards. Being open and honest is generally appreciated by patients, even in challenging situations.

9.3 Competence and capacity

The difference between competence and capacity

Consent can only be taken from patients who are deemed to be "competent", i.e. who understand the information and are capable of making a rational decision by themselves. Competence is a legal judgement.

Doctors also frequently talk about "capacity to consent" or "mental capacity". This is a medical judgement. Capacity is formally assessed by doctors and nurses who must be sure that a patient is able to understand the proposed management, to comprehend the risks and benefits and to retain that information long enough to make balanced choices.

Because "competence" and "capacity" have similar meanings (in effect, a judge would rule as "competent" someone who has the capacity to make medical decisions), most doctors use them interchangeably.

Both competence and capacity are situation and time specific, i.e. they are determined at a particular point in time, in relation to a given treatment or procedure. So, for example, a patient may be competent enough to decide whether they agree to have their blood pressure taken, but not whether they should go ahead with a limb amputation.

Determining if someone has capacity to consent / is competent

Before you can obtain consent from a patient, you must ensure that they are competent, i.e. that they have the capacity to make the decision to go ahead with the proposed treatment or procedure.

The assessment of mental capacity should be made in accordance with the Mental Capacity Act 2005 (or the Adults with Incapacity Act 2000 in Scotland). Essentially, a patient is considered to have capacity if he:

- Understands the information provided in relation to the decision that needs to be made
- Is able to retain the information
- Is able to use and weigh up the information
- Can communicate his decision, by whatever means possible.

Every adult is presumed to have capacity

English law dictates that every adult should be assumed to have capacity to consent unless proven otherwise. Essentially, this means that the patient retains full control of decisions affecting his care (i.e. his autonomy) unless someone challenges this assumption and conclusively proves otherwise.

A seemingly irrational decision does not imply lack of capacity

If a patient makes a decision that you consider irrational (such as refuses life-saving treatment), it does not mean that they lack capacity. Similarly, you should not presume that someone is incompetent because they have a mental illness, are too young, can't communicate easily, have beliefs that go against yours or make decisions with which you disagree.

If you are unsure about your assessment

There may be situations where you are unsure as to whether a patient should be considered to have capacity to consent or not. In such cases, you should:

- Ask the nursing staff who know the patient about their ability to make decisions

- Involve colleagues with more specialist knowledge such as a psychiatrist or a neurologist

Some hospitals have a clinical ethics team who can consider the particulars of the case and advise. If you are still unsure you should seek legal advice as a court may need to make that decision.

9.4 Seeking informed consent from a competent patient

Definition of informed consent

Informed consent is the agreement, granted by a patient, to receive a given treatment, or have a specified procedure performed on them, in full consideration of the facts and implications. The following sections summarise the key issues that you need to be aware of for your interview.

Basic model to obtain informed consent from competent patients

When the patient is competent, seeking informed consent is a relatively straightforward process, as follows:

Step 1: The patient and the doctor discuss the presenting complaint. During the consultation, the doctor gauges the level of understanding of the patient, takes account of their views and values, and presents a range of possible management options.

Step 2: The doctor describes the available options, including:

- Diagnosis and prognosis, including degree of certainty and further investigations required
- Different management options available to the patient, including the outcome of receiving no treatment. It is likely that the doctor will recommend a preferred course of action, but he should in no circumstances coerce the patient
- Details of any necessary investigations/treatments and/or procedures, including their purpose, their nature and which professionals will be involved
- Details of the risks, benefits, side-effects and likelihood of success. The doctor should inform the patient of any serious possible risks (e.g. death, paralysis, etc.) even if the likelihood of occurrence is very small. He should also inform the patient about less serious side-effects or complications if they occur frequently
- Whether the procedure or treatment is part of a research programme or innovative treatment, as well as their right to refuse to participate in research or teaching projects
- Their right to a second opinion.
- Any treatment which you or your Trust cannot provide, but which may be of greater benefit to the patient. This may include procedures for which no one has been trained in your hospital, or treatments not provided by your trust on grounds of cost, but which may be provided elsewhere.

The information should be provided using terms that the patient can understand and the doctor should check the understanding of the patient, answering the patient's questions as appropriate. When asked questions, the doctor should endeavour to respond in the most informative manner, avoiding coercion. If necessary, the doctor should use all necessary means of communication, including visual aids, leaflets, and models.

Step 3 The patient weighs up the benefits and risks and determines whether to accept or refuse the proposed options. If the patient refuses, then the doctor should explore their reasons and continue the discussion as long as the patient wants to. There may be concerns which were not identified or addressed previously. The doctor should inform the patient that they have the right to a second opinion and the opportunity to change their mind later on, if they so wish.

There are circumstances when further procedures may be necessary during the primary planned procedure (e.g. blood transfusion, or doing a different surgical procedure). You need to explain these anticipated risks to the patient clearly and obtain consent for these potential procedures (otherwise you will need to wake the patient up to seek further consent).

Who should seek consent from the patient?

The responsibility to seek consent from the patient rests with the doctor who is proposing the treatment or will be carrying out the procedure. It is possible to delegate the task to someone else, but only if the person seeking the consent is suitably trained and qualified and they have appropriate

knowledge of the treatment/procedure and the associated risks. Although the task of consenting is delegated, the responsibility still rests with the doctor who is proposing the treatment or doing the procedure.

Verbal v. written consent

The importance of recording consent is to demonstrate that the process took place with due care and diligence and that both parties had a shared vision of the proposed procedure and any key complications.

In many cases, implied or verbal consent is sufficient. For example, if a patient undresses so that you can examine them, their compliance constitutes consent.

For simple or routine procedures, investigations or treatment, verbal consent may be sufficient. However, you must make sure that the patient has properly understood the information provided and has taken an informed decision. You should also ensure that their consent is duly recorded in their notes, together with the information on which it was based.

You should get written consent:
- For complex or more involved procedures
- If there are serious risks involved
- If there are potential consequences for the patient's employment, social or personal life
- When providing clinical care is not the primary purpose of the investigation or procedure
- When the treatment is part of a research or innovative programme
- For procedures where written consent is required by law (such as organ donation or fertility treatment).

9.5 Dealing with a patient who lacks capacity

When a patient lacks capacity, the doctor must provide care which is in the patient's best interest. It is preferable for the patient to be as involved as they can be in any discussion about their care.

Whatever decisions are being taken by the doctor, the patient should be treated with respect, dignity and should not be discriminated against. In making decisions on behalf of the patient, the doctor should take account of a wide range of issues, including:

- Whether the patient has signed an advance directive stating how he wants to be treated in situations when he can't give informed consent

- The views of any individuals who are legally representing the patient or whom the patient has said they wanted to involve

- The views of any individuals who are close to the patient and may be able to comment on their beliefs, values and feelings (e.g. their relatives)

- Whether the lack of capacity is temporary (e.g. the patient may be temporarily unconscious) or permanent.

Unless the patient has signed an advance directive, the management decisions will rest with the doctor. Legally, relatives and others only have an advisory role. In practice, the doctor should try to seek a consensus around the care of the patient by involving all relevant parties in the discussions.

Sometimes there are disagreements, either between the doctor and the rest of their team, or between the medical team and those close to the patient. In situations such as these, it is important to seek conflict resolution through negotiation. Useful resources could include consulting more experienced colleagues, using mediation services or independent advocates. In cases of more severe disagreements then legal advice should be sought and a court decision may be needed.

9.6 Competence / capacity in children

Can children give informed consent?
All children aged 16 or above can be assumed to be competent, i.e. essentially they can be treated in exactly the same way as an adult. Children under the age of 16 can give consent to a treatment, procedure or investigation if they are deemed to be Gillick competent, in reference to a famous House of Lords ruling on the ability of children under 16 to consent – see 9.7 for details on the Gillick case.

A child is deemed Gillick competent if they can understand, retain, use and weigh the information given and their understanding of benefits, risks and consequences.

Involving the parents
Even if a child is competent enough to make a decision to consent to a given procedure or treatment, you should make every effort to encourage the child to involve their parents. Whatever their involvement, parents cannot override consent given by a competent child.

Can children refuse treatment?
In Scotland, the situation is simple. Children can refuse treatment and the child's decision cannot be overridden by the parents. In England, Wales and Northern Ireland, no minor can refuse consent to treatment, when consent has been given by someone with parental responsibility or by the court. This applies even if the child is competent and specifically refuses treatment that is considered to be in their best interest. This is a rare event and you should seek legal advice through your Trust and your defence union. Enforcing treatment on a child against their will poses risks which need to be weighed up against the benefits of the procedure or treatment. You will also undoubtedly need to involve other members of the multidisciplinary team and an independent advocate for the child.

The above is the essential information that you will be required to know for most interviews. If you are applying for Paediatrics or Obstetrics and Gynaecology, or want further detail on children's consent, you can consult the GMC booklet *0-18 years – guidance for all doctors* online at www.gmc-uk.org.

9.7 Gillick competence & Fraser guidelines

In specialties where children are involved, questions are sometimes asked that require some basic knowledge of Gillick competence and Fraser guidelines.

These two concepts both relate to the ability of children to give consent for treatment, without the need for parental consent or knowledge. However, many candidates misunderstand or confuse the two concepts. In reality, although linked, they are slightly different. The purpose of this section is to explain what they mean and how they differ.

Gillick competence – The House of Lords ruling
In 1980 the Department of Health and Social Services (DHSS) advised doctors that children under the age of 16 could be prescribed contraception, without parental consent.

Mrs Gillick, the mother of ten children including five daughters, sought a declaration from the House of Lords that the DHSS guidance was unlawful and adversely affected parental rights and duties. Her main arguments were that the decision was the same as administering treatment to a child without consent (which should rest with the parents), and that this encouraged others to commit the offence of having sexual relationships with a minor. Although she had won 3:0 in the Court of Appeal, she lost 2:3 in the House of Lords.

In 1985, the House of Lords panel, led by Lord Fraser, ruled that parental rights did not exist and that, if a minor was competent, they could consent to treatment without the parents being able to veto that decision. It was also ruled that the test of competence for minors should be the same as the test for competence for adults. This is now referred to as "Gillick competence". Although the Gillick case was originally solely about contraception, the ruling was general and applies to any treatment, investigation or procedure.

Further ruling
In 1990, a further ruling stated that a "Gillick-competent" child can prevent their parents from viewing their medical records. Consent must be sought explicitly.

Fraser guidelines
Following on from the Gillick case, Lord Fraser released further guidelines specifically relating to contraception (which can also be extended to abortion).

These guidelines state that a doctor or other health professional providing contraceptive advice or treatment to someone under 16, without parental consent, should be satisfied that:

- The young person will understand the advice;
- The young person will understand the moral, social and emotional implications;
- The young person cannot be persuaded to tell their parents or allow the doctor to tell them that they are seeking contraceptive advice;
- The young person is having, or is likely to have, unprotected sex whether they receive the advice or not;
- Their physical or mental health is likely to suffer unless they receive the advice or treatment; and
- It is in the young person's best interests to give contraceptive advice or treatment without parental consent.

9.8 Mental Capacity Act 2005 (effective 2007)

Although no in-depth knowledge of the Mental Capacity Act 2005 is required, other than perhaps for Psychiatry interviews at ST4 level, candidates will be expected to know its key points. Indeed, candidates in many specialties have been asked what they know of the Mental Capacity Act 2005. Some have been given scenarios where some basic knowledge of the Act was required.

Many of the Mental Capacity Act 2005's provisions have been described in previous sections on consent. This section summarises the key components of the Act.

Purpose of the Act
The Act formalises best practice and common law principles, in relation to the care of patients who lack capacity, and those who make decisions on their behalf.

Assessing lack of capacity
- No one can be assumed to lack capacity simply because they have a specific medical condition.

- Lack of capacity cannot be established in relation to someone's age, appearance or behaviour which may lead others to make assumptions. So, for example:
  - children are not necessarily lacking capacity simply because they are young
  - someone who is unkempt does not necessarily lack capacity simply because they are not looking after themselves
  - Someone behaving eccentrically or making decisions which appear unusual or counter-intuitive does not necessarily lack capacity.

- Any action or decision taken on behalf of someone who lacks capacity must be taken in their best interest. Best interest can be assessed by asking the patient to write their wishes down (e.g. advanced directive) and by consulting those who are familiar with the patient, e.g. relatives or carers.
- Anyone providing care to a person who lacks capacity can do so without the risk of incurring legal liability, provided that capacity has been properly assessed and that care is being provided in line with the patient's best interest.

- The use or threat of force (called "restraint") is only permitted if the person using it believes that it will prevent harm to the patient who lacks capacity.

Making decisions on behalf of an incapable patient & legal framework

- A patient with capacity is allowed to appoint an attorney to make health and welfare decisions on their behalf, should they ever lose capacity. This is called "Lasting Powers of Attorney" (LPA).

- Deputies may be appointed by the courts to make decisions in relation to welfare, healthcare and finances, though they cannot refuse consent to life-sustaining treatment. These court-appointed deputies will be supervised by the newly-created post of Public Guardian.

- A new Court of Protection has been set up to provide final rulings on matters of capacity.

Protecting vulnerable people

- If a patient lacks capacity, but has no one to speak on their behalf, then an Independent Mental Capacity Advocate (IMCA) can be appointed to represent them. The IMCA cannot make decisions, but represents the patient by bringing to the attention of decision-makers (e.g. doctors) the important factors that need to be considered, such as the patient's beliefs, feelings and values. The IMCA can also challenge decisions on behalf of the patient.

- Advanced decisions to refuse treatment: patients may provide an advanced statement that they refuse to receive treatment should they lose capacity in the future (e.g. DNR orders). The Act states that the advanced decision can only be valid if a proper process has been followed. In particular, the statement must be in writing, signed and witnessed. For an advanced statement to be valid in cases of life-threatening events, the document must state explicitly that it is valid "even if life is at risk".

Using incapable patients in research (this section would be relevant for those applying to academic posts)

- Any research involving patients lacking capacity should be approved by a Research Ethics Committee. One condition is that there is no other alternative, i.e. that the research cannot be carried out using patients who have capacity instead.

- Approval should be sought from carers or nominated third parties before the patient can participate in the research. In particular, they should make a judgement as to whether the patient would have wanted to be involved.

If the patient concerned refuses to be involved or shows any sign of resistance, then they should not be included.

9.9 Consent when dealing with emergencies in the clinical setting

If you are dealing with emergencies in the clinical setting, then all the rules described in previous sections apply.

If a patient is competent at that time and needs a procedure, you should seek consent, even if only verbal.

If the patient is not competent and you cannot determine the patient's wishes through the relatives or other sources, then you can treat them without their consent, on the condition that the treatment that you administer is limited to what is immediately necessary to save their life or prevent a serious deterioration of their condition. The guidelines also specify that the treatment you provide must be the least restrictive of the patient's future choices. If the patient regains capacity, you should explain what was done. For any other treatment beyond the strict minimum, you should seek consent from the patient.

For children, the same applies. The guidance issued by the GMC in *0-18 years: guidance for all doctors*[9] states that "you can provide emergency treatment without consent to save the life of, or prevent serious deterioration in the health of, a child or young person". Of course, this does not preclude you

[9] www.gmc-uk.org/guidance/ethical_guidance/children_guidance_index.asp

from involving the parents. If the parents disagreed with your emergency treatment, then you would be entitled to proceed with what you perceived to be in the best interest of the child.

9.10 Dealing with emergencies outside the clinical setting

Occasionally questions are asked about the behaviour you should adopt if an emergency takes place outside the clinical setting (e.g. you are on a plane or on holiday).

Do you have to get involved?
To answer this question, there are two principles to consider:

GMC guideline (Good Medical Practice 2013, article 26)
This describes your medical responsibility as a doctor as: "You must offer help if emergencies arise in clinical settings or in the community, taking account of your own safety, your competence and the availability of other options for care."

Essentially this means that, providing you are safe (e.g. not in the middle of a busy motorway or under physical threat by someone) and providing you will not make things worse, then you are obliged to help.

Situations where a doctor may not be competent to help would include someone who has been out of clinical practice for a long time and may actually harm the patient by intervening directly. In that situation they should ensure that the right people are called. In an emergency in a completely different specialty, the patient may be better off being sent to hospital straight away, rather than being treated on site.

You need to make a judgement based on the circumstances. If you are in the middle of the jungle, there is no way the patient will ever get to a hospital, and the only alternative is death, their best bet may be you, even if you feel shaky in your knowledge. Essentially you must weigh up the different options and ensure that you choose the alternative which is best for the patient.

The law
In the UK, unlike the US, there is no specific "Good Samaritan" law. In fact, under UK law, there is no obligation for anyone (including a doctor) to assist another human who needs resuscitation or emergency assistance, unless that person has caused the problem in the first place.

Therefore, from a legal perspective you can choose to ignore an emergency if you wish, BUT from a medical perspective the GMC will require you to get involved as set out in the previous paragraph. If you refuse to get involved or choose to ignore the matter, you won't be sued, but you would be in breach of the GMC's duties of a doctor and may be reported to the GMC if this is discovered.

What if you do get involved and it goes wrong?
As soon as you get involved with an emergency outside the clinical setting, then you have a duty of care towards the patient and must act in their best interest. This means that you may be legally liable if your intervention leaves the patient in a worse position than if you had not intervened.

If the alternative for the patient was death (e.g. if he was arresting), then there is no problem; any action is better than no action providing it is in line with what would be expected in those circumstances. However, if the patient is not in danger of death you must think carefully about your actions to ensure that the patient does not come to more harm, than if no action had been taken.

10 NHS issues and hot topics

Most candidates have limited knowledge of NHS structures and policy; as a result, many worry that they could face difficult factual questions which they would be unable to answer.

On the whole, questions on NHS issues are designed to test your general understanding of the issues rather than detailed knowledge of any particular topic. In other words, you are more likely to be asked "How do you feel the specialty will be affected by current NHS changes?" than "Tell us everything you know about the Darzi report". You should therefore make some effort to familiarise yourself with key issues likely to affect the specialty to which you are applying and reflect on their significance to your career and your specialty. By demonstrating a good understanding of these issues, you will present yourself as a mature candidate with strong motivation.

Different types of questions

NHS issues can be tested at interview in three main ways:

- Knowledge questions about a specific topic, e.g. "What is the role of the Care Quality Commission?"
- Awareness questions such as "What do you think about the increasing role of the private sector?"
- Application questions, i.e. questions which require putting together a range of ideas such as "What are the issues affecting this specialty at the moment?" or "How do you see this specialty evolving over the next 5 or 10 years?"

As well as being tested through standard interview questions, your knowledge of NHS issues can be tested through presentations and group discussions.

What the interviewers are looking for

The interviewers will be looking for three features:

- The effort that you have put into keeping abreast of current developments relevant to your specialty, and therefore your motivation for the specialty.
- Your ability to analyse the impact of these issues on your work environment and the health system in general, and therefore your debating ability and general level of maturity.
- Your ability to communicate your ideas in a structured and convincing fashion.

Specialty-specific NHS issues and hot topics

In some interviews, you may be asked about specific documents or issues relating to your specialty. This could include National Service Frameworks (NSFs) and specific NICE or other guidelines. To ensure that you can answer all these questions, you should consult the following sources of information:

- The NHS website for NSFs[10]
- The NICE website[11]
- The relevant Royal College's website[12]

You should ask some of your senior colleagues to point you in the direction of specialty-specific issues and guidelines that are topical at the time of your interview. You should also read specialty-

[10] http://www.nhs.uk/nhsengland/NSF/pages/Nationalserviceframeworks.aspx
[11] http://www.nice.org.uk/
[12] See Chapter 19

specific papers as interviewers sometimes ask questions on papers that have recently been published.

General NHS issues and hot topics

These are general topics that apply to most specialties. This includes issues such as the current NHS drive towards better quality and more efficiency, the issues of patient choice and increased competition, or issues relating to the impact of current reforms on medical training. It is crucial that you understand the key messages and are able to present your own opinion of the possible impact on the department to which you are applying. It is important to be aware that most reports have a brief Executive Summary that gives the highlights and is easier to digest if you're short of time.

This book contains details of the major issues and institutions which you may be asked about. All these issues have been raised at ST interviews in the past or are current major topics so make sure that you are familiar with them.

A sensible word of advice

In the whole scheme of things, questions on NHS issues do not get asked at many interviews. Having surveyed post-interview junior doctors who attended ISC Medical's courses, fewer than 10% of candidates had been asked questions requiring any specific knowledge of current topics. These had been asked mainly at ST3/ST4 interviews (though there had been a few exceptions, with some Ophthalmology ST1 interviews containing questions on the threat that Independent Sector Treatment Centres may represent, for example).

In the course of your preparation, although it is important that you gain an overview of current issues, beware not to get bogged down with significant detail as this is never probed into. All that will be required of you is an overall understanding of these issues; the summaries that follow will be more than enough to help you achieve the required level of understanding.

I would advise strongly that you allocate the majority of your preparation time to all the other types of questions addressed in previous chapters – particularly if you are short of time.

10.1 Overview of the NHS in England

Commissioning of services

In England, each hospital essentially operates as an independent business. The decision as to which healthcare provider is allowed to provide which services is made by Clinical Commissioning Groups (CCGs), which consist mainly of local GPs and managers (with a few representatives from hospitals). So, for example, a local CCG may decide that Hospital X should no longer provide hip replacement surgery, because from now on such surgery should be provided by Hospitals Y and Z only.

Legislation that came into effect in 2013 has made it possible for external providers (e.g. charities or even private companies) to offer NHS services. So, for example, a local CCG could decide to award a contract for cataract surgery to a private company rather than to the local hospital (though of course they would need to have a good reason to do that: a good reason being that they feel the private company may provide better quality of care). The process of awarding contracts is known in the NHS as "commissioning".

Because CCGs are local groups and consist mainly of GPs, they cannot commission GP services themselves. Similarly, they can't commission services that need to be provided on a more global scale because of their specialist nature, such as heart and lung transplant surgery or eye cancer care, for two reasons:

1. They don't have the skills and knowledge to understand the exact nature of those services.

2. Those services are provided on a regional or national basis.

Instead, both primary care services and specialist services are commissioned by a higher body, which used to be called the NHS Commissioning Board but is now known simply as NHS England.

Block Contract vs. Payment by Results

Before 2005, hospitals were paid a fixed amount of money every year, designed to cover the cost of healthcare. That system was called "block contract". If a hospital needed more money (i.e. was in deficit compared to their budget), then the government would simply pay more money to that hospital. Conversely if a hospital spent less money (i.e. showed a profit against its budget), then it would have to pay it back to the government. The problem with that approach was that there was no incentive for hospitals to save money or work efficiently.

In 2005, the Labour government introduced the principle of "Payment by Results", whereby a tariff would be set nationally for each clinic and each procedure. Hospitals would no longer receive a fixed amount of money but would instead be paid for each activity they undertook.

So, for example, a hip replacement might have a tariff of £5,000, which would cover the cost of the hospital stay, imaging, the surgery and some follow-up. The amount of the tariff would be set roughly at the average of the cost across all Trusts, meaning that some hospitals would make a loss and others would make a profit. The idea was to encourage those who made a loss to work more efficiently so that they could make a profit and survive.

Pros and cons of Payment by Results

Though there is no doubt that Payment by Results is forcing the NHS to become more efficient, the jury is out as to whether it actually leads to better care. In truth, it is difficult to predict how the situation will evolve, mainly because one needs to give the system a chance to settle before analysing whether the change has been successful. In reality, it is likely that parts of the system will do very well whilst others may struggle to make it work.

At an interview, your concern is simply to demonstrate that you understand the principles and to show an awareness of the main pros and cons. Here are some of the more common positive and negative arguments:

- The tariff is calculated as an average of the actual cost of the procedure or investigation. This means that a number of Trusts will have actual costs below the tariff and will therefore make a profit, whilst other Trusts will have actual costs above the tariff and will therefore make a loss. This will encourage the Trusts that make a loss to become more efficient and may therefore lead to greater cost-efficiency.

- Trusts who find it difficult to become efficient (maybe because they don't do that many cases of a specific type) will need to merge with other Trusts to build economies of scale, or may stop providing some services. This may create local inequalities and increase pressure on service provision in neighbouring places.

- Trusts are paid on the basis of what they code into their IT system. There is therefore a much greater obsession with recording every single activity so that the Trust can be paid accordingly. Also, coding is left to each Trust to carry out. This may lead to abuse (as some departments may be very liberal in their coding). The whole system therefore relies on trust.

- Payment by Results places the emphasis on quantity rather than quality, i.e. the more you work, the more money you get. Although this is a good way to ensure that patients are dealt with quickly (particularly in an environment where waiting time is a common measure of success of the system), it can also be detrimental to patient safety. Action was taken so that hospitals did not just focus on making a profit but also provided quality care to patients. Such actions included:

    - Giving patients the choice of where they wanted their care to be provided, whereby the GP would give patients a list of hospitals to which they could go and the patient would then choose the place that suited them most: the hope being that patients would make the choice on the basis of the quality of care they expected to receive.

- Imposing targets that had to be reached (for example, max 4-hour wait in A&E, max 18-week wait for elective surgery).

- Ensuring that hospitals were penalised for poor quality care (for example, by ensuring that, if a patient had to be readmitted to hospital following a complication of the surgery, the hospital would have to deal with that complication without expecting to be paid).

- Introducing incentives to provide enhanced standards of care. For example, the NHS introduced a sort of bonus scheme called CQUIN (Commissioning for Quality and Innovation), which rewards departments that enhance the quality of care of their patients. GPs were encouraged through a sort of bonus scheme too (called QOF – Quality of Outcomes Framework). In addition, hospitals that succeeded in providing best practice care to their patients could benefit from higher tariffs in some specialties.

- Increasing competition between healthcare providers.

- There is controversy about the way in which the tariffs are calculated. Some Trusts argue that their population does not match any kind of national average and the risk that they may lose money is therefore greater than for other Trusts. This can sometimes lead to locally negotiated tariffs to take account of special circumstances.

10.2 The role of the private sector in the provision of healthcare in England

There are several ways in which the private sector is involved and, although you will not need to know any of this in much detail, you must know enough to understand which part of the private sector an interview question is referring to before you can answer it. The different types of private providers are as follows:

1. ***Private practice doctors (referred to as "private healthcare"):*** this normally refers to doctors working for private hospitals or for themselves who provide healthcare to individual private patients. Examples of private healthcare providers include BUPA or AXA PPP. These private providers have been around for a long time and are normally used by patients to bypass the NHS waiting lists. Patients either pay for the care themselves or through a private healthcare insurance company. The doctors involved in private healthcare are often the same as those working for the NHS, who undertake private activities in their spare time. The prices charged by those private providers are subject to market forces and are typically much higher than the standard NHS tariff for the same procedures.

   So, for example, if a patient has been told that they would need to wait 4 months to get a hip replacement on the NHS but they want it earlier, that patient can go to a private orthopaedic surgeon who will perform the operation a lot sooner. The patient will then have to pay with their own money unless they have private insurance. In exchange they can expect more attention from staff, their own private room and a guarantee to be seen by a consultant.

2. ***External (i.e. non-NHS) providers contracted to do NHS work:*** this refers to private companies, charities or other organisations who have been officially commissioned to provide healthcare to NHS patients at NHS tariffs. An example of this is Virgin Care who provides services to NHS patients in areas as diverse as breast cancer screening, paediatric physiotherapy, sexual health services or dermatology clinics. Those services are commissioned by the CCGs, and are provided at no direct cost to the patient. Basically this is NHS care provided at NHS tariffs by non-NHS providers.

It is the introduction of those private providers contracted to do NHS work that has led many to fear a "privatisation of the NHS". Here are the arguments commonly presented for and against such a system (which we have tried to present in as balanced a way as possible):

- Private companies are run for profit. There is a risk that they will therefore favour making a profit over providing good quality care. The counterargument to this is that the NHS has been run on a not-for-profit basis for many years and has not always provided the best quality care it could (see, later, the section on the Mid-Staffordshire Trust). In addition, though there is some anecdotal evidence that some private companies engage in dubious practices or do not deliver in line with expectations, this is not widespread (and again the NHS has its own share of dubious practices too).

- Private companies may "cherry-pick" the easy cases that are the most profitable, leaving the NHS burdened with the more complex, loss-making cases. The answer to that argument is that it is, indeed, true for the simple reason that one would not want those private companies to take on complex cases they can't handle. Those companies would be asked to handle the simple high volume work to ensure that that work is being done efficiently without interference from other work such as emergencies; it follows then that the NHS (with more expertise than the private sector) should handle the more complex cases that it has been trained to handle well. The reason NHS trusts may be losing money on those more complex cases is because the tariffs have not been calculated well enough to ensure they can cover their costs. However, it is a matter of time before this anomaly is resolved.

- "Privatisation" will lead to fragmentation of care. If different aspects of care are given to different providers then healthcare may be provided in many more venues than under the old system (where basically care was only provided either in a GP practice or in a hospital). This may mean that patients will have to travel to different places in order to be seen, which will cause issues with patient records, for example, since there is no central database that can be accessed from everywhere.

- The fragmentation of care described in the previous paragraph will also lead to training issues. External providers will be handling the simple cases, which are those used as part of medical training. A private company that needs to make a profit may be reluctant to train doctors if that leads to a loss of profit.

- There are risks of conflict of interest amongst doctors. Many of those external providers are, in fact, at least partially owned by doctors. For example, many out-of-hours services are owned by GPs. Some hospital consultants have also set up external businesses, which could be competing against the same hospital trust in which they work. The commissioning of such services therefore has to be done in an open and transparent manner.

10.3 Patient choice

Patient choice as a driver for reform

The right of patients to have choice followed a long evolutionary process and was recently made a legal right. You will find below a chronological outline showing how consecutive reforms have been driven by and have improved patient choice:

1948	The start of the NHS. Patients can choose their GP, optician and dentist.
1972	People are considered consumers. The NHS is reorganised to become more responsive to the needs and choices of its users. People begin to be given the choice of the treatment they can receive and can also elect to be treated privately.
1989	The NHS is increasingly tailoring its service to individual patients. Patients are also given more information about services and treatments so that they can choose. Choices range from the time to place of treatment.
2000	Patients are to be given more information to support their choice of GP and date and time of hospital appointment. The NHS plan promises that, by 2005, every patient will be able to choose a convenient appointment time rather than being imposed one by the hospital. Where a patient's operation has been cancelled and the hospital cannot offer a new date within 4 weeks, the patient can elect to be treated at a time and hospital of his choice.

2002 The pilot for Patient Choice begins. Patients with coronary heart disease are offered faster care from alternative providers, including the independent sector.

2003 Publication of the White Paper*: Building on the best. Choice responsiveness and equity in the NHS.* The paper proposes a more responsive NHS which offers more choice and information across all areas of healthcare. It empowers patients by involving them in their own treatment.

2006 All patients requiring treatment can choose between four or five hospitals and new treatment centres. Options include NHS trusts and Foundation trusts, specialist services provided by GPs within their surgeries, new treatment centres and some existing independent sector providers. The year 2006 also sees the introduction of the Choose and Book system, which enables patients to make their choices online or by phone.

2006 The White Paper *Our health, our care, our say: a new direction for community services* asks local authorities to provide more information to patients on GP practices (e.g. whether they take new patients, opening hours, the range of services provided). People with long-term conditions are encouraged to do more to care for themselves through the provision of better information and by means of a care plan.

2007 Launch of the NHS choices website: a 250,000-page online resource providing details on every aspect of the services patients may receive including hospitals' and doctors' profiles, performance, and up-to-date information about conditions and treatments (meaning the information will no longer only come from doctors).

2007 The government announces a major review of the NHS which will engage patients as well as staff. The review is to be conducted by Lord Darzi, an eminent surgeon, who sets out a vision based less on central direction and more on patient control, choice and local accountability.

2008 The choice of hospital, first introduced in 2006, is expanded to enable patients to choose any hospital of their liking providing it meets NHS standards. Patients with long-term conditions also get more choice.

2009 Publication of the *NHS Constitution*, which sets out the rights of patients and the pledges the NHS is required to meet. It covers access to services, quality of care and environment, access to treatment, medicines and screening programmes, respect, consent and confidentiality, informed choice, patient involvement in healthcare and public involvement in the NHS, complaints and redress.

2010 Publication of the White Paper *Equity and Excellence: Liberating the NHS*, which sets out the intention to place patients at the centre of everything the NHS does. It promises focus on what matters to patients, i.e. outcomes.

2011 Introduction of the "Any Qualified Provider" scheme, which gives patients the ability to choose from a range of approved providers such as hospitals and high-street service providers. Patients and GPs are able to choose a service based on what matters to them, e.g. geographical location, shorter waiting times, better outcomes, etc.

2011 Choice of named consultant-led team. The government announces that NHS patients in England will have the freedom to choose who provides their hospital care. For example, some patients may choose a consultant who has the best experience whilst other patients might choose a consultant who has successfully treated them in the past. There are no geographical boundaries.

2012 Enactment of the Health and Social Care Act. It does away with Primary Care Trusts (PCTs) and Strategic Health Authorities and transfers commissioning powers to Clinical Commissioning Groups, which are partly run by GPs. The act promotes the involvement of patients and carers in decisions about their care and treatment and is designed to further enable patient choice.

2012 The first *NHS mandate* between the government and the new NHS Commissioning Board

(nowadays renamed NHS England) outlines the ambitions of the NHS. The mandate is structured around five key areas of improvement:

1. Preventing people from dying prematurely
2. Enhancing quality of life for people with long-term conditions
3. Helping people to recover from episodes of ill-health or following injury
4. Ensuring that people have a positive experience of care
5. Treating and care for people in a safe environment and protecting them from avoidable harm.

2013 NHS England (previously known at the NHS Commissioning Board) assumes responsibility for the delivery and support of choice within the NHS for patients, working with Clinical Commissioning Groups (CCGs).

Consequences, pros and cons of patient choice

- Patient choice offers more flexibility for patients. For example, a patient may want to go to a hospital that is further away but has a lower waiting time than their local hospital. As choice become national (and not just local), patients have the opportunity to visit hospitals with a better reputation which are further away. Patients who want to be looked after by their relatives in a different part of the country after an operation may choose to have the procedure done where their relatives live rather than near their own home.

- Giving patients the choice means they are more likely to choose appointments that suit them, which therefore reduces the "Did Not Attend" (DNA) rates.

- The services that provide good care may become overwhelmed by demand, leading to increased waiting time. At the extreme, patients may end up having a choice simply between a good service for which they have to wait a long time or a poor service available at short notice. This may push the more desperate patients to go for the poor but rapidly available solution.

- There is controversy as to whether patients actually want choice. In many cases, patients find it difficult to make a choice either because the system is confusing or simply through a lack of interest. In fact, many patients may ask their GP to recommend a choice for them, which defeats the object of patient choice.

- The information is provided to patients in a simplified form and can sometimes be difficult to interpret.

- Discussing the possible choices with patients will increase consultation time at the GP level. However, this may be partially compensated for by a generally reduced administrative burden.

10.4 Darzi Next Stage Review 2007-2008 – High Quality Care for All

Professor Ara Darzi is an academic based at St Mary's Hospital, London: an eminent colorectal surgeon and health minister. The Darzi Next Stage Review was commissioned by the government to set a vision for the NHS in the 21st century. The final report was issued in June 2008 and a key theme was that there would be no new targets from central government. Another theme was that clinicians would be encouraged to be practitioners, partners and leaders in the NHS. This would mean working together across professional and physical boundaries to provide more integrated care. Clinicians would be expected to lead, rather than just manage, the service: i.e. to create a shared vision with staff and patients of what success looks like and to drive improvements in quality and safety.

In this section I have summarised the main features of the report written by Lord Darzi. Please note that this summary refers to Primary Care Trusts (PCTs) because those were in place when the report was written. PCTs have now been replaced by Clinical Commissioning Groups (CCGs).

Emphasis on quality

Since 2000, much emphasis had been placed on encouraging the healthcare system to develop capacity and volume. Amongst other things, this was encouraged through the waiting list initiative, designed to clear the backlog of cases and reduce waiting time by encouraging nurses to develop new roles, by encouraging GPs to take on new responsibilities and by developing the role of the private sector. However, encouraging volume of care meant that quality was not always the main focus and many of the recommendations made by Lord Darzi were designed to place the focus back on quality (hence the subtitle "High quality care for all"). New measures and regulations included:

- The creation of a National Quality Board to advise ministers on priorities for NICE. There would also be regional quality boards.

- The replacement of the Healthcare Commission by the Care Quality Commission (CQC).

- The introduction of Regional Quality Observatories to stimulate local improvement efforts.

- The Payment by Results tariff would no longer just depend on volume, but also on quality of care received by the patient. This would be determined through feedback provided by patients.

- The linking of consultants' clinical excellence awards (bonuses) to
  - Clinical activity
  - Clinical leadership
  - Quality of care.

Quality would be measured on patient experience (through specific validated questionnaires), safety, clinical outcomes and quality accounts.

Emphasis on prevention

The NHS should invest in maintaining patients in good health, and not simply treating them. To maintain this drive towards wellbeing:

- Each Primary Care Trust should commission wellbeing and prevention services, with the main targets being obesity, drug addiction, alcohol harm, sexual health, smoking and mental health.

- "Coalition For Better Health" – a set of agreements between the government and other organisations to improve health – would be implemented. For example, there would be a focus on obesity, with encouragement to eat more healthily and do more exercise, as well as an encouragement for companies to invest more in the health of their employees.

- A vascular risk assessment campaign for people aged between 40 and 74 would be run.

- Support would be provided to GPs with better incentives for prevention.

- People on ill-health who wanted to get back to work would be supported. The primary focus would be patients with back problems and mental ill health.

Better access for patients

- Improving access to care, in particular through the creation of 150 GP-led health centres (so-called polyclinics), which would reflect local needs. These would open from 8am to 8pm and there would be no obligation to register (i.e. a patient could be registered at their own GP and still use the polyclinics). Those who wished to register at a polyclinic may do so if they wished. Polyclinics may offer services in the evening and at weekends depending on local need. They would provide a one-stop shop where people could access GP services and specialist outpatient services.

  [Note: pretty much all the polyclinics that were set up failed to get off the ground, mainly because they could only really work in large cities where people found that they then had to travel much further than their own GP practice or their local hospital to get the care they wanted.]

Better information to patients

- Patients would be given information on cleanliness and infection rates, on experiences such as satisfaction, dignity and respect, and on measures of outcomes that would include patients' views on the success of treatments.

- New quality indicators (quality "metrics") would be developed in consultation with interested parties to determine what information patients should be given. Clinical Dashboards (i.e. information boards) would be developed to inform patients about statistics such as waiting time, speed of test results, length of stay, complications, etc.

Increased control for patients and greater patient influence over resources

- Personal care plans for patients with long-term conditions, agreed by a professional and a lead professional.

- Personal budgets for patients with long-term conditions. These budgets would be handled on behalf of the patient, though there are plans for direct payments to be piloted.

Better access to effective treatment

- A new NHS constitution would make it explicit that patients are entitled to NICE-approved drugs if their doctor felt they were appropriate. For drugs not yet appraised by NICE, the local PCT would have an obligation to provide an open and honest explanation if funding for the treatment was refused.

- NICE should ensure that the approval process is reduced to a few months (and not up to 2 years or more as was the case at the time).

Increased risk management

- Greater emphasis on combating infections with earlier powers would be given to the Care Quality Commission.

- Regular National Patient Safety Agency (NPSA) initiatives, including first one on catheter-related bloodstream infections.

- US-style "Never events" would be defined, for which no payment will be received (e.g. if procedure done on the wrong side).

10.5 White Paper 2010 – Equity & Excellence – Liberating the NHS

On 12 July 2010, the coalition government released a new White Paper setting out the proposed direction for the NHS. This White Paper was designed to build on the successes of previous governments whilst addressing some of the key problems that had plagued the NHS over the previous years.

The key points of the new direction included:

- Giving patients greater choice and control, and equipping them to make decisions through the provision of a greater range of data.

- Focusing on clinical outcomes rather than targets, building on Lord Darzi's review and particularly its focus on quality. The aim was to provide continuous improvement through reduced bureaucracy and greater focus on clinical outcomes.

- Empowering clinicians and other healthcare professionals to use their judgement and innovate. This bottom-up approach was designed to draw upon the strengths and knowledge of front-line staff, ridding the system of the top-down approach much criticised in the past, with decisions taken centrally by less-informed politicians.

The following paragraphs constitute a summary of the main points raised by the White Paper:

Liberating the NHS

- Age discrimination to be abolished (e.g. patients above or below a certain age being entitled to certain drugs). Note that this was not so much a new policy of the government. It was imposed through a European Directive.

- More power devolved to local NHS institutions with less interference from Whitehall. "We will be clear about what the NHS should achieve; we will not prescribe how it should be achieved."

- Greater powers to local clinicians. This involved a radical simplification of the hierarchy and the removal of several layers of management. Monitor (which regulates Foundation Trusts and ISTCs) would become the regulator.

- A greater focus on reducing inequalities and improving public health, with the creation of a new Public Health Service.
- NHS spending to be increased in real terms every year over the lifetime of the parliament (i.e. until 2015), but accompanied by efficiency savings.

Putting patients and the public first

Shared decision making

- One of the key mottos of the White Paper was "no decision about me without me". The report therefore reinforced the idea of patient choice and patient involvement. This was to be supported by an increase in the amount of information being made available to patients on conditions, treatments, lifestyle choices and on how to look after their own and their family's health. In essence, better informed patients are more likely to want an input in their own care, and less likely to defer to clinicians' opinion blindly.

- Patient Reported Outcome Measures (PROMs) tools should be used more widely.

Greater availability of information and more accountability

- Data collected on patient experience and real-time feedback would take more prominence and would also be made publicly available, as would all data relating to the quality of services delivered by the various clinical services and departments. It was expected that the use of Quality Accounts would be perfected and disseminated to ensure that the public was made fully aware of the quality of care provided by the various services.

- Greater control to be given to patients over their own health records. Patients would be able to decide who can access their records and to see changes whenever changes are made. This was expected to apply to GPs to start with, to be extended to other services later on.

Increased choice and control

- The Paper quoted the 2009 British Attitudes Survey which states that 95% of patients think there should be some choice over which hospital they should attend and the treatment they should receive. In the interest of debate, note that this is not the same as saying that, once given the choice, patients would be prepared or happy to exercise it (in fact GPs often complain that patients end up either choosing on the basis of proximity or defer the choice to the GP).

- The paper complained of the fact that the Labour government's attempt to introduce choice was too restricted to the choice of provider. The new government aimed to:

    - Increase the current offer of choice of any provider significantly.

    - Create a presumption that all patients would have choice and control over their care and treatment, and choice of any willing provider wherever relevant.

    - Introduce choice of named consultant-led team for elective care by April 2011 where clinically appropriate, and maximise the use of Choose & Book. Note that the patient would not necessarily be seeing the consultant, but his/her team. A patient may still be seen by a trainee or a nurse for example.

    - Extend maternity choice, and help make safe, informed choices throughout pregnancy and in childbirth a reality – recognising that not all choices would be appropriate or safe for all women – by developing new provider networks.

    - Begin to introduce choice of treatment and provider in some mental health services from April 2011, and extend this wherever practicable.

    - Begin to introduce choice for diagnostic testing, and choice post-diagnosis, from 2011.

    - Introduce choice in care for long-term conditions as part of personalised care planning. In end-of-life care, there would be a move towards a national choice offer to support people's preferences about how to have a good death. The government would work with providers, including hospices, to ensure that people had the support they needed.

    - Give patients more information on research studies that are relevant to them, and more scope to join in if they wished.

    - Give every patient a clear right to choose to register with any GP practice they want with an open list, without being restricted by where they lived. People should be able to expect that they can change their GP quickly and straightforwardly if and when it is right for them, but equally that they could stay with their GP if they wished when they move house.

    - Develop a coherent 24/7 urgent care service in every area of England that makes sense to patients when they have to make choices about their care. This would incorporate GP out-of-hours services and provide urgent medical care for people registered with a GP elsewhere.

Patient and public voice

A new consumer champion called HealthWatch England should be created within the Care Quality Commission to look after the interest of patients and ensure that patient views and feedback are taken into account.

Improving healthcare outcomes

The government intended to build on the principles of quality set out in the Darzi report. Having already modified some of the key targets for the year 2010-2011, the government wanted to ensure that

targets with no clinical relevance were scrapped and replaced by evidence-based measures and targets.

The NHS outcome framework
The government would set out the key outcomes that needed to be achieved and would leave it to local authorities to determine how those objectives would be best achieved.

This would target three distinct areas of quality:

- The effectiveness of the treatment and care provided to patients – measured by both clinical outcomes and patient-reported outcomes
- The safety of the treatment and care provided to patients
- The broader experience patients have of the treatment and care they receive.

Quality standards and incentives for improvement
- NICE to develop 150 quality standards over the next 5 years.
- Quality would be rewarded financially (an old idea formalised by Darzi but never really put into practice to date).
- Tariffs would be refined and the implementation of best-practice tariffs (i.e. higher tariffs payable to those providing the best possible care) would be accelerated.
- The CQUINs payment framework would be extended and poor quality care may be penalised by fines (Note: this penalisation policy is one which was adopted by the Labour government for underperforming schools – this backfired, with underperforming schools having less money to invest to make improvements, causing them to underperform even further. Such policy would therefore require careful implementation and management).
- Payments to pharmaceuticals expected to be reviewed to provide better value.

Autonomy, accountability & democratic legitimacy

GP consortia (now renamed Clinical Commissioning Groups or CCGs)
Commissioning powers would be devolved to GPs through the creation of GP consortia. They would be expected to be responsible for 80% of the budget.

NHS Commissioning Board (now renamed NHS England)
This new independent board would oversee the commissioning process and issue guidelines. It would design the structure of the tariffs and other incentives, though actual tariff levels would be set by Monitor. The board would also ensure full patient participation and involvement, and would oversee the GP consortia. In addition it would commission services not commissioned by consortia such as maternity services and very specialised services. The commissioning function would therefore be taken out of the PCTs' hands and PCTs would therefore be abolished, saving around £1 billion per year in administration costs alone.

Freeing existing NHS providers
All Foundation Trusts would be freed of current constraints and it was expected that all Trusts would become Foundation Trusts within 3 years (Note: the Labour government had previously set a deadline of December 2008, which was never met).

The Care Quality Commission would monitor the quality of healthcare provided whilst Monitor would act as an economic regulator from April 2012. Monitor's role would be to promote competition and regulate prices.

How the White Paper was received

Concerns were raised by many trade unions and think tanks. Many feared it represented the path to privatisation of the NHS. There was also great concern at the fact that Monitor's role was to promote competition, suggesting the government intended the death of the NHS and a buoyant private sector.

Very rapidly, PCTs, SHAs and – after the Arm's Length Body (ALB) review – a number of ALBs started planning for abolition. This resulted in loss of staff and low morale. The remaining staff had to maintain the functions of their organisations, save money and support the development of the new GP consortia.

10.6 Health & Social Care Act – 2011 and onwards

The Bill's infancy

The 2011 Health and Social Care Bill was published in January 2011. It was essentially the legal document setting out the legislation for the implementation of the clauses contained within the 2010 White Paper. The Bill received its second reading and completed its committee stage in the House of Commons on 31 March 2011. It received a stormy ride and was unlikely to pass through the House of Lords. With local and national elections planned for May 2011, the Health Secretary made a statement to the House of Commons on 4 April 2011 and, in an unprecedented move, paused the process, engaging in what has come to be known as the "listening exercise". He set up an independent group to review the Bill. The group was known as the NHS Future Forum. The group reported its findings and recommendations to the government on 13 June 2011. On 21 June 2011 the House agreed to return the Bill and its amendments to the Committee stage (on 28 and 30 June 2011).

The NHS Future Forum

The NHS Future Forum consisted of 45 members led by Professor Steve Field, a previous Chairman of Council, Royal College of GPs. It included patient representatives, clinicians, and leaders of voluntary care and social care organisations and charities. Over 8 weeks, 6,700 people attended listening events and 25,000 emailed comments. There were four key themes:

- Choice and Competition
- Public Accountability and Patient Involvement
- Clinical Advice and Leadership
- Education and Training.

The main conclusions were as follows:

- There was no other choice but to respond to pressures placed upon the system by rising demand, demographic and technological change, and the tough financial climate by improving quality and productivity on a scale not previously achieved.

- Competition should be seen as a tool for supporting choice, promoting integration and improving quality. It should never be pursued as an end in itself. Monitor's role in relation to "promoting" competition should be significantly diluted.

- The pace of change needed to be slowed and more time needed to be allowed for plans for education and training to be considered.

- The Bill should be amended to place a new duty on the NHS Commissioning Board and commissioning consortia to actively promote the NHS Constitution.

- The Bill should require commissioning consortia to obtain all relevant multi-professional advice to inform commissioning decisions. In support of this, there should be a strong role for clinical and professional networks in the new system and multi-specialty clinical senates should be estab-

lished to provide strategic advice to local commissioning consortia, Health and Wellbeing Boards and the NHS Commissioning Board.

- Managers would have a critical role to play in working with and supporting clinicians and clinical leaders. Experienced managers should be retained in order to ensure a smooth transition and support clinical leaders in tackling the financial challenges facing the NHS.

- Private providers should not be allowed to "cherry pick" patients and the government should not seek to increase the role of the private sector as an end in itself.

The government's response (June 2011)

The Department of Health published its full response to the NHS Future Forum report, detailing its proposed changes to its plans for the modernisation of health and social care. A summary of the key changes from the response are outlined below.

Overall accountability for NHS
Some people had raised concerns that the Bill would weaken NHS principles or the government's overall responsibility for the NHS. To make clear that this was not the case, amendments to the Bill would:

- Require the NHS Commissioning Board and Clinical Commissioning Groups to take active steps to promote the NHS Constitution, which enshrined the core principles and values of the NHS

- Make explicit that the Secretary of State remained fully accountable for the NHS

- Create explicit powers for the Secretary of State to oversee and assess the national NHS bodies, to ensure they are performing effectively, while respecting their operational independence.

Clinical advice and leadership
The Forum's report showed there was universal agreement that patient care was better if it was based on input from those closest to patients – doctors, nurses and other health and social care professionals – in discussion with patients and carers, the voluntary sector, and other healthcare partners.

However, the Department of Health had also heard that, to do this well and really make a difference to patients and carers, there was a need to be more ambitious. Consequently steps would be taken to:

- Make sure that a range of professionals play an integral part in the clinical commissioning of patient care, including through clinical networks and new clinical senates hosted by the NHS Commissioning Board (now called NHS England) and stronger duties on commissioners to obtain an appropriate range of clinical advice to ensure that at least one registered nurse and secondary care specialist doctor are appointed to Clinical Commissioning Groups' governing bodies.

- Embed clinical leadership throughout the new arrangements and support leadership skills to develop.

- Support Clinical Commissioning Groups to make high quality, evidence-based decisions, with information joining up to support integrated care.

- Provide more clarity around the proposed arrangements for supporting the development of Clinical Commissioning Groups, authorising them to take on commissioning responsibilities and ensuring ongoing accountability for their role in improving the quality of care.

Public accountability and patient involvement
The Future Forum agreed with the Department of Health that patients and carers should be at the heart of the NHS, through shared decision making about their care and meaningful involvement in how health services are organised. But the Future Forum also said that, if this were to be achieved, more needed to be done to ensure that shared decision making became the norm and that new organisations were sufficiently accountable for the decisions they made.

In response to these recommendations, steps would be taken to:

- Strengthen the accountability of new organisations, including Clinical Commissioning Groups
- Ensure more joined-up local services by strengthening requirements for close working between Health and Wellbeing boards and Clinical Commissioning Groups
- Strengthen the duties of organisations across the system with regard to patient, carer and public involvement
- Strengthen the definition of involvement to reflect better the principle of “no decision about me without me”
- Ensure that clinical commissioning groups (CCGs) received a quality premium only where they can demonstrate good performance in terms of quality of patient care and reduced inequalities in healthcare outcomes.

Choice and competition

Nearly everyone who contributed to the listening exercise felt that patients should be given more choice and control over their care. Some felt that the competition that accompanies increased choice brought benefits for patients, while others were concerned about its impact on existing NHS providers and integrated services.

The NHS Future Forum said that, while competition has a role to play, the government should make its position clearer and guard against the dangers of competition being an end in itself. The Department of Health heard this message and proposed to improve its plans as follows:

- The Bill would l rule out any deliberate policy to increase or maintain the market share of any particular sector of provider – private, voluntary or public.
- Monitor’s core duties would be focused on protecting and promoting patients’ interests, not on promoting competition as though it were an end in itself.
- Existing rules on cooperation and competition in the NHS would be kept.
- There would be additional safeguards against cherry-picking and price competition.
- Limits on Monitor’s powers to take action against commissioners would be set.
- Extension of Any Qualified Provider would be phased.
- Monitor would be required to enable integration of services for patients.
- Duties on commissioners to promote integrated services would be strengthened.
- The NHS Commissioning Board (since renamed NHS England) would promote innovative ways of demonstrating how care can be made more integrated, including exploring opportunities to move towards single budgets for health and social care.
- As recommended by the Forum, the Secretary of State’s mandate to the NHS Commissioning Board would set clear expectations about offering patients choice: a “choice mandate”.
- Personal health budgets would be set as a priority, subject to evidence from the current pilots.

Developing the healthcare workforce

The NHS Future Forum highlighted that there was strong support for their proposals to improve arrangements for professional development. But they also said that further work was needed to develop detailed proposals following consultation.

The Department of Health would further develop and revise its plans to make sure it got them right. In particular, it would:

- Ensure that Health Education England is in place quickly to provide national leadership and strong accountability, a whole workforce and multi-professional approach, with strong relationships with health, care and education partners.

- Ensure a safe and robust transition for the education and training system. During transition, LETBs (the new name for 'deaneries') would continue to oversee the training of junior doctors and dentists, and the Department of Health would give them a clear home within the NHS family.

- Put in place a phased transition for provider-led networks to take on their workforce development responsibilities when they could demonstrate their capacity and capability.

- Further consider how best to ensure funding for education and training is protected and distributed fairly and transparently, and publish more detail in the autumn 2012.

- Ensure high quality management is valued across the NHS, with a commitment to retaining the best talent across the PCTs and SHAs.

Timetable for change

A transition plan was set in place to ensure that all changes would be implemented by April 2013.

Amendments by House of Lords (February – March 2012)

Some 2000 further amendments were made to the Bill in the winter of 2012, most of which dealt with points of detail. Some of the most salient amendments included the following:

- Secretary of State accountability: Putting beyond doubt the Secretary of State's responsibility and accountability with respect to a comprehensive health service.

- Greater patient involvement: Patients would have a greater say in their health, with the NHS Commissioning Board and Clinical Commissioning Groups having stronger duties to promote patient involvement in their own care.

- Education and training: The NHS Commissioning Board and Clinical Commissioning Groups would have new responsibilities to support education and training, strengthening the links between workforce planning and education and training.

- Health inequalities: A new duty on the Secretary of State, NHS Commissioning Board and Clinical Commissioning Groups to report annually on their progress in tackling health inequalities.

- Strengthening integration**:** Making clear that the health regulator Monitor would have the power to require healthcare providers to promote integration of NHS services.

The Bill was given Royal Assent on 27 March 2012, thereby becoming the Health and Social Care Act 2012.

10.7 The new commissioning landscape (From 2013)

NHS Commissioning Board (NCB) – now called NHS England

Having taken up its full statutory duties from April 2013, its purpose is to:
- Ensure the NHS delivers better outcomes for patients
- Ensure a fair and comprehensive service across the country
- Promote the NHS Constitution and champion the interests of patients
- Use choice and information to empower people to improve services.

It is also responsible for commissioning primary care and publishing data on GPs, and for enabling and facilitating Clinical Commissioning Groups (CCGs).

It hosts the NHS Leadership Academy (which replaced National Leadership Council) and the New Improvement Body (which replaces the National Patient Safety Agency, NHS Institute for Innovation and Improvement, NHS Improvement and others)

Its head offices are in Leeds and London, and it also has 4 regional offices and 18 local area teams. The NHS Commissioning Board is held to account by the Department of Health.

Clinical Commissioning Groups (CCGs)

Clinical Commissioning Groups are groups of GPs that, since April 2013, are responsible for designing local health services in England. They do this by commissioning or buying health and care services including:

- Elective hospital care
- Rehabilitation care
- Urgent and emergency care
- Most community health services
- Mental health and learning disability services.

Clinical Commissioning Groups work with patients and healthcare professionals and in partnership with local communities and local authorities. On their governing body, CCGs have, in addition to GPs, a least one registered nurse and a doctor who is a secondary care specialist. Groups have boundaries that do not normally cross those of local authorities. Clinical Commissioning Groups are responsible for arranging emergency and urgent care services within their boundaries, and for commissioning services for any unregistered patients who live in their area. All GP practices have to belong to a Clinical Commissioning Group.

The aim of this is to give GPs and other clinicians the power to influence commissioning decisions for their patients.

CCGs are overseen by NHS England, which is a national body formed under the 2012 Act. Local offices of NHS England oversee CCGs and also manage primary care commissioning, including holding GP practices' NHS contracts.

Health and Wellbeing Boards

Health and Wellbeing Boards (set up April 2013) act as the local system leader through work on Joint Strategic Needs Assessments (JSNA) and Joint Health and Wellbeing Strategies (JHWS), and NHS organisations need to be active leaders within this process. The JHWS sets shared priorities and a plan for what the NHS and local authorities can do individually and collectively to deliver seamless care, improved outcomes and reduced health inequalities. The JSNA and JHWS inform CCGs' commissioning plans and support integration of delivery.

10.8 Other key bodies

The General Medical Council (GMC)

The GMC has four distinct roles:

- Keeping a register of all qualified doctors. In practice no doctor can practise in the UK without being registered with the GMC.

- Fostering good medical practice. It does so by issuing guidance on standards that doctors need to adhere to, such as *Good Medical Practice.*

- Promoting high standards of medical education and training. The GMC sets and monitors standards for post-undergraduate and postgraduate trainees. It also provides guidance to ensure that doctors are supported in their continuing professional development.

- Dealing with doctors who may not be fit to practise.

The Royal Colleges

Royal Colleges are institutions charged with setting standards within their field and for supervising the training of doctors within that specialty. Most of them grant membership to doctors only once they have passed a number of examinations.

Existing colleges include:

- Royal College of Surgeons of Edinburgh (RCSEd)
- Royal College of Physicians of London (RCP)
- Royal College of Physicians and Surgeons of Glasgow (RCPSG)
- Royal College of Physicians of Ireland (RCPI)
- Royal College of Physicians of Edinburgh (RCPE)
- Royal College of Surgeons of Ireland (RCSI)
- Royal College of Surgeons of England (RCS)
- Royal College of Obstetricians and Gynaecologists (RCOG)
- Royal College of General Practitioners (RCGP)
- Royal College of Pathologists (RCPath)
- Royal College of Psychiatrists (RCPsych)
- Royal College of Radiologists (RCR)
- Royal College of Ophthalmologists (RCOphth)
- Royal College of Anaesthetists (RCoA)
- Royal College of Paediatrics and Child Health (RCPCH)
- College of Emergency Medicine (CEM) (This one is not Royal!)

National Institute for Health and Care Excellence (NICE)

NICE is an independent organisation providing guidance on health promotion and the prevention and treatment of ill health. It provides guidance in the following areas:

- Health technologies, i.e. which new or existing medicines, medical devices, procedures, diagnostic techniques or treatment should be used within the NHS. NICE makes recommendations as to which medicine, investigations, devices or procedures should be used, not only on the basis of their effectiveness but also on the basis of cost. NICE focuses on the principle of “value for money”. NICE therefore plays an important role in the rationing of drugs, treatments and investigations in the NHS.

- Interventional procedures: in essence, NICE assesses the safety of a range of procedures and provides information about their safety. It can then recommend a procedure for routine use or specify any special steps that should be taken when seeking consent from patients for the least safe procedures. These guidelines are different to other guidelines as they are mostly informative rather than prescriptive.

- Clinical practice, i.e. which treatments are appropriate for people with specific diseases or conditions. NICE also produces guidelines that are designed to improve the quality of care of patients with specific conditions or diseases. These clinical guidelines are based on the best available evidence but do not replace the clinician's judgement, which still needs to be exercised. They can therefore be considered as "a guide that should be followed unless there is a good reason not to do so".

- Public health: the Centre for Public Health Excellence (part of NICE) publishes guidelines on nine different areas: smoking and tobacco control; obesity, diet and nutrition; exercise and physical activity; alcohol; sexual health; mental health; drug misuse; promoting the health of children and young people; preventing accidental injury. The guidance can provide advice on the amount and level of information that should be given to the population on these key areas; it can also take the form of recommendations on strategies to address key issues such as smoking cessation or teenage pregnancies.

Care Quality Commission (CQC)

The independent regulator of all health and social care services in England, the Care Quality Commission inspects hospitals, care homes, GP surgeries, dental practices and other care services to ensure they meet national standards of quality and safety.

Monitor

Monitor is a regulator looking after the health of the finances of NHS trusts. It regularly assesses NHS trusts to ensure they are well led, in terms of both quality and finances.

Health Education England (HEE)

Health Education England assumed full operational responsibilities from April 2013. HEE's role is to provide leadership for the new education and training system and to ensure that the shape and skills of the future health and public health workforce evolve to sustain high quality outcomes for patients in the face of demographic and technological change.

HEE ensures that the workforce has the right skills, behaviours and training, and is available in the right numbers, to support the delivery of excellent healthcare and drive improvements. HEE supports healthcare providers and clinicians to take greater responsibility for planning and commissioning education and training through the development of Local Education and Training Boards (LETBs), which are statutory committees of HEE.

The establishment and development of HEE was set out in *Liberating the NHS: Developing the Healthcare Workforce, From Design to Delivery*, the government's policy for a new system for planning and commissioning education and training. The driving principle for reform of the education and training system is to improve care and outcomes for patients and HEE exists for one reason alone – to help ensure delivery of the highest quality healthcare to England's population, through the people we recruit, educate, train and develop.

HEE's key national functions of the organisation include:

- Providing national leadership for planning and developing the whole healthcare and public health workforce.

- Authorising and supporting development of Local Education and Training Boards and holding them to account.

- Promoting high quality education and training which is responsive to the changing needs of patients and communities and delivered to standards set by regulators.

- Allocating and accounting for NHS education and training resources – ensuring transparency, fairness and efficiency in investments made across England.

- Ensuring security of supply of the professionally qualified clinical workforce.

- Assisting the spread of innovation across the NHS in order to improve quality of care.

- Delivering against the national Education Outcomes Framework to ensure the allocation of education and training resources is linked to quantifiable improvements.

Local Education and Training Boards (LETBs)

There are 13 Local Education and Training Boards that are responsible for the training and education of NHS staff, both clinical and non-clinical, within their area. The LETBs, which are committees of HEE, are made up of representatives from local providers of NHS services and cover the whole of England. They are:

- East Midlands
- East of England
- Yorkshire and the Humber
- North East
- North West
- West Midlands
- South West
- Wessex
- Thames Valley
- North West London
- South London
- North Central and East London
- Kent, Surrey and Sussex

LETBs have the flexibility to invest in education and training to support innovation and development of the wider health system. They are also able to ensure that money in the new system follows students and trainees on the basis of quality and education and training outcomes. They are key in ensuring that the system responds to the recommendations of the Francis report (see next section) and in helping to improve the quality of care at every turn.

10.9 Mid-Staffordshire NHS Foundation Trust: Francis inquiries

Background

In 2009 the Healthcare Commission (the old NHS regulator) published the findings of an investigation into failings in care at the Mid-Staffordshire NHS Foundation Trust. Focusing on problems at Stafford Hospital, the investigation found widespread failings in care. A local campaign group Cure the NHS, led by Julie Bailey whose mother died at the hospital, campaigned for an inquiry. The previous government ordered two Department of Health investigations and then a secret inquiry led by Robert Francis QC that lacked legal powers and focused on problems at the hospital, not wider failings.

The new coalition government ordered a full legal inquiry under Robert Francis QC who was recognised to have led the first inquiry with sensitivity and care. This inquiry was charged with looking into failings by the various bodies and regulators that are supposed to prevent problems in care persisting.

One of the most worrying things about the scandal was that the Trust had managed to achieve coveted "foundation status" whilst the problems were ongoing. This process required the support of the local Department of Health (known as Strategic Health Authorities), the NHS financial regulator Monitor and the Department of Health directly, including a government minister.

The Healthcare Commission report (March 2009)

The report highlighted a series of failures, particularly in A&E, AMU and on some medical and surgical wards. Those concerns related to:

- Poor nursing standards
- Lack of effective management systems for emergencies
- Failure to identify and act on high mortality rates for patients admitted as emergencies
- A Board detached from day-to-day reality of patient care
- Failure by the Board to develop an open culture and to challenge current practice despite information pointing to obvious problems.

The report qualified the care received by patients as “appalling” and mentioned that this likely led to hundreds of unnecessary deaths. In March 2009, the Chairman was asked to resign by Monitor and the Chief Executive of the Trust resigned in order to avoid being suspended and investigated by the Board.

In December 2009, a review published by the Royal College of Surgeons qualified the Trust as “dysfunctional” and “frankly dangerous”.

The first Francis inquiry (2010)

The first inquiry was designed to identify key failures and make recommendations. Led by Robert Francis QC, it identified a “bullying culture, target focused in which the needs of the patients were ignored”, and “an appalling failure at all levels”.

Key failures identified included:

Board failures

- The Board buried its head in the sand, failed to appreciate the enormity of the issues, reacted too slowly and generally downplayed the significance of many of the issues identified.
- The Board responded to the Healthcare Commission report with denial. It showed no lack of urgency to resolve the issues raised.
- The CEO had concluded that high mortality rates were due to coding issues.
- The Board set out to gain foundation status in order to improve the Trust’s governance, making it its number 1 priority. This likely distracted it from dealing with more basic care-related issues.
- There was much focus on finances (the Trust had been making losses for a few years). To save £10m (8% of its turnover), the Trust set out to make cuts, including removing 150 posts. Wards were badly reorganised (separate floors for surgery and medicine without carrying out any risk assessment), beds were cut and consequently patient care was compromised.
- Poor governance (clinical audit practice underdeveloped, critical incidents not reported or not acted upon, investigation of complaints done by staff from the area which caused the problem in the first place (and not seen by the Board)).

Staff-related issues

- Too few consultants and nurses.
- Constant change of management, leading to lack of leadership.
- Doctors isolated from managers, the Board and each other.
- Some key individuals were unsafe.
- Lack of attention to patient dignity (incontinent patients left in degrading conditions, patients left inadequately dressed in full public view, patients handled badly – sometimes by unskilled staff – causing pain and distress, rudeness, hostility, failure to refer to patients by name).
- Poor communication (lack of compassion and sensitivity, lack of information about patients’ condition and care, lack of involvement of patients in decisions. Friends and family often ignored, failure to listen and reluctance to give information, staff not communicating well with each other, wrong information provided to patients and relatives).
- Poor diagnosis and management (slow or premature discharge of patients, discharge from A&E without appropriate diagnosis or management, poor record keeping, poor or delayed diagnosis).
- Buzzers left unanswered

Cultural issues

- Patients concerned about insisting on proper care for fear of upsetting staff or of reprisals.
- Staff distracted by their own mobile phones.
- Staff not focused on basics (litter left on the floor, alcohol gel not replenished and therefore not used).
- Low staff morale.

The second Francis inquiry (2013)

The second inquiry focused on commissioning, supervision and regulation of the hospital, querying particularly why such serious issues were not identified earlier and acted upon sooner. The inquiry highlighted the following issues:

- Too much focus on finance, figures, targets and not enough on patient care (recent reforms emphasise outcomes rather than targets) and failure to put patients first.
- Criticism of nursing training and lack of compassion in nursing profession.
- Lack of accountability – attitude that it's someone else's problem e.g. managers vs. clinicians vs. Board vs. politicians. Key will be new Friends and Family test (at Mid Staffs only ¼ of staff would have recommended the hospital).
- Defensiveness, secrecy and complacency – focusing relentlessly on positives and closing eyes to negatives, i.e. poor standards.
- Doctors failed to speak up for patients.
- PCTs and SHAs had blind trust in the hospital's management and accepted their reassurance without further checks.
- Monitor and CQC did not challenge enough.
- The Royal College of Nursing was not supportive enough of its members when they raised concerns.
- Department of Health too remote.
- GPs did not raise concerns until after the issues came to light.

Amongst the 290 recommendations the report made, here are some of the key ones:
- There should be more focus on compassion and caring in nursing recruitment, training and education.
- Patient safety should be the number 1 priority in both medical and nursing training and education.
- Individuals and organisations would have a duty to speak up (the government is in fact considering the possibility of criminal prosecution for staff who don't).
- Quality accounts should be published in a common format and made public.
- The profession of healthcare assistants should be regulated.
- For the elderly, one person should be in charge of individual patient care.
- The RCN should be either a royal college or a trade union.
- Patient involvement must be increased.
- Structural change is not the answer.

The government's response (27 March 2013)

- Duty of candour to be placed on NHS boards to be honest about mistakes.
- Consideration being given to making individual doctors and nurses criminally responsible for covering up errors**.**
- New ratings system for hospitals and care homes based on Ofsted scheme used in schools.
- Posts of Chief Inspector of hospitals and care homes to be created; and possibly primary care.
- Nurses to spend up to a year working as a healthcare assistant so they get experience providing basic care such as washing and dressing.
- Managers who fail in their jobs to be barred from holding such positions in the future.
- Code of conduct and minimum training standards for healthcare assistants, but not full registration scheme as recommended by inquiry.
- Tough rules to be drawn up to allow Trusts to be put into administration when basic standards are not met unless problems can be resolved quickly.
- Department of Health civil servants to be forced to spend time on the front line of the NHS.
- Prof. Don Berwick was asked to set up an inquiry into "making harm a zero reality in the NHS" – National Advisory Panel on the Safety of Patients.

10.10 The Keogh Review

The review, started in February 2013, was led by Professor Sir Bruce Keogh, the National Medical Director for the NHS in England. It looked at the quality of the care and treatment provided by 14 trusts identified as having higher than average death rates in the two years before the start of the review. Eleven of these trusts are to be put under 'special measures' in order to improve governance.
The review has revealed problems in care that had not been exposed before. While the report says immediate safety issues found were dealt with straight away, it also calls for co-ordinated efforts to improve care and accountability in the longer term.

Why was the Keogh review commissioned?

The review was commissioned by the prime minister, David Cameron, and the secretary of state for health, Jeremy Hunt, in response to the findings of the Mid Staffordshire Public Inquiry. It aimed to look into the quality of care and treatment being provided by English hospital trusts with higher than average death rates in the previous two years.

While above average death rates can often be accounted for by other factors (such as the hospital serving an area with an older population), previous health scandals have shown that particularly unusual results in data ("outliers") should never be ignored.

The 14 trusts were selected on the basis of having higher than average scores on one of two well-established measures of death rates. These are:

- the hospital standardised mortality ratio (HSMR), which compares the expected rate of death in a hospital with the actual rate of death
- the summary hospital level mortality indicator (SHMI), which compares death rates between individual hospitals

The report set out to:

- determine whether there are any ongoing failings in the quality of care provided to patients at these 14 hospital trusts
- identify whether the trusts' actions to improve quality is adequate and whether additional steps are needed
- identify if any additional support should be made available to the trusts
- identify any areas that may require legal (regulatory) action to protect patients

What data did the Keogh review look at?

The review was carried out in three stages and considered the performance of the hospitals across six main areas:

- deaths
- patient experience
- workforce
- clinical and operational effectiveness
- leadership
- governance

Stage 1 – information gathering and analysis

All information covering the six key areas was gathered for each trust and analysed. Findings were then compared with national average standards. Areas of concern were followed up in a visit to the hospital involved.

Stage 2 – rapid responsive review

Review teams were trained to carry out planned and unannounced site visits at each of the 14 trusts for two or three days at a time. These teams were made up of 15-20 people and included patients, doctors, nurses, managers and regulators. The visits involved walking the wards and talking to patients, trainees, staff and senior executives. Findings were recorded in a rapid responsive review re-

port. Individual interviews and approximately 70 staff focus groups were carried out as part of a cultural assessment.

Stage 3 – risk summit and action plan

Once the reviews were completed, a meeting ("risk summit") was held to agree a coordinated plan of action with each trust, including support to speed up improvements and identify who was accountable.

What were the key findings of the Keogh report?

The report found examples of good care as well as areas where improvement is urgently required. In the report, Professor Sir Bruce Keogh said: "We found pockets of excellent practice in all 14 of the trusts reviewed. However, we also found significant scope for improvement, with each needing to address an urgent set of actions in order to raise standards of care." Key findings from the review include:

- Understanding that concepts such as excess deaths and avoidable deaths are more complex than analysing a single-level summary death rate indicator (two widely used death rate indicators were the basis of results of this review).

- There are many different causes of high death rates and there is no "magic" solution.

- Death rates in NHS hospitals have been falling over the past 10 years and the rate of improvement in the 14 hospitals under review has been similar to other NHS hospitals.

- Factors often claimed to be associated with higher death rates (such as access to funding and poor health of the local population) were not found to be statistically associated with the results of these hospitals.

- Accuracy of clinical coding (the way hospitals make a computerised record of diseases, operations and other "healthcare episodes") can impact on death indicator numbers. For example, the review says that coding patients to make them appear sicker or identifying a higher amount of multiple conditions can improve death rates, but arguably represents an attempt to "fix the figures". Some hospitals were said to not be responding to the signals the figures were identifying as they felt they were incorrect, which is potentially a matter of concern.

- More than 90% of deaths in hospital happen when patients are admitted in an emergency rather than for a planned procedure. The review says it is therefore not surprising that all of the 14 hospital trusts had higher deaths in urgent and emergency care, and only one trust (Tameside General Hospital) had high death rates for elective procedures.

- Understanding the causes of higher death rates is said not to be about finding a "rogue surgeon" or problems occurring in a single specialty area. The review says it is more likely to be a combination of problems that all hospitals in the NHS experience, such as busy A&E departments and wards, treatment of the elderly, and the need to recruit and keep excellent staff.

Where areas of concern were found in any of the trusts, immediate action was taken, including:

- immediate closure of operating theatres
- suspension of out-of-hours stroke services
- instigating changes to staffing levels
- dealing with backlogs of complaints from patients

The review identified areas of action in the next two years as well as some common themes and barriers to delivering high quality care. These themes are:

- A limited understanding of how important and simple it can be to genuinely listen to the views of patients and staff, and engage them in how to improve services.

- The ability of hospital boards and leaders to use data to drive quality improvement. This theme is made more difficult by how hard it is to access data held in different places and different ways across hospitals systems.
- The complexity of using and interpreting summary measures of death (HSMR and SHMI).

Conclusion

In a letter to the secretary of state, Professor Keogh reports that assessments of the 14 hospital trusts have been highly rigorous and uncovered problems in care that had not been exposed before. He warns against hasty reactions and pointing the finger of blame.

Any immediate safety issues discovered are said to have been dealt with. Professor Keogh states that considered debate is needed, as well as co-ordinated efforts to improve care with a future focus on accountability.

This model is likely to be replicated when the Chief Inspector of Hospitals conducts his inspections.

10.11 The Berwick report

Professor Don Berwick, an international expert in patient safety, was asked by the Prime Minister to carry out the review following the publication of the Francis Report into the breakdown of care at Mid Staffordshire Hospitals. The main recommendations from the report, published in August 2013, were as follows:

1. The NHS should continually and forever reduce patient harm by embracing wholeheartedly an ethic of learning.

2. All leaders concerned with NHS healthcare – political, regulatory, governance, executive, clinical and advocacy – should place quality of care in general, and patient safety in particular, at the top of their priorities for investment, inquiry, improvement, regular reporting, encouragement and support.

3. Patients and their carers should be present, powerful and involved at all levels of healthcare organisations from wards to the boards of Trusts.

4. Government, Health Education England and NHS England should assure that sufficient staff are available to meet the NHS's needs now and in the future. Healthcare organisations should ensure that staff are present in appropriate numbers to provide safe care at all times and are well-supported.

5. Mastery of quality and patient safety sciences and practices should be part of initial preparation and lifelong education of all health care professionals, including managers and executives.

6. The NHS should become a learning organisation. Its leaders should create and support the pability for learning, and therefore change, at scale, within the NHS.

7. Transparency should be complete, timely and unequivocal. All data on quality and safety, whether assembled by government, organisations, or professional societies, should be shared in a timely fashion with all parties who want it, including, in accessible form, with the public.

8. All organisations should seek out the patient and carer voice as an essential asset in monitoring the safety and quality of care.

9. Supervisory and regulatory systems should be simple and clear. They should avoid diffusion of responsibility. They should be respectful of the goodwill and sound intention of the vast majority of staff. All incentives should point in the same direction.

10. We support responsive regulation of organisations, with a hierarchy of responses. Recourse to criminal sanctions should be extremely rare, and should function primarily as a deterrent to wilful or reckless neglect or mistreatment.

10.12 Revalidation

The origins of revalidation

The idea of revalidation arose many years ago at the result of several medical scandals. Its aim is to ensure doctors' fitness to practise. Revalidation aims to protect patients from poorly performing doctors, promote good medical practice and increase public confidence in doctors.

Under the original proposals, doctors would have submitted records of appraisals, including personal development plans and feedback. They would also have submitted CPD records. Based on that evidence the GMC would have decided whether to revalidate a doctor or insist on further action.

The 5th Shipman Report and suspension of revalidation

Following the Shipman affair, in which Dr Shipman, a GP, had single-handedly murdered hundreds of his patients over a number of years without being suspected or detected, an inquiry was conducted by Dame Janet Smith into the various components of the scandal. This included an inquiry into the role of the GMC, which resulted in the so-called 5th Shipman Report. The report essentially criticised the GMC for looking after doctors more than after patients and for not taking reasonable steps to protect patients by revalidating doctors properly. It also highlighted the poor sharing of information on doctors' performance between the professional, educational and regulatory bodies. The GMC's role was also criticised, particularly the fact that it sets the rules, investigates doctors and passes judgement on their actions.

When the GMC was criticised for letting Harold Shipman kill hundreds of victims unnoticed, it defended itself by presenting revalidation as the answer to the problem.

The Shipman case mainly concerned a failure by the NHS to audit Shipman's activities in a number of areas including:

- Cremation forms (and a second signature more or less applied without checks).
- A high mortality rate amongst his patients (all of whom were elderly and whose deaths were simply dismissed as unlucky or natural).
- A discrepancy in the prescription of diamorphine and other controlled drugs (all the more bizarre since Shipman had already been suspended by the GMC for stealing drugs in the 1970s).

It was established that Shipman was well liked by colleagues and patients, and therefore would have passed appraisals with flying colours. He also kept up to date and would have had no problem being revalidated on the basis of those two criteria only. As a result the GMC had no choice but to suspend revalidation (before it was fully introduced) and to go back to the drawing board.

Better doctors, safer patients (14 July 2006)

On 14 July 2006, Professor Sir Liam Donaldson, the Chief Medical Officer (CMO), published his review into the regulation of the medical profession. The report was designed to address the criticism raised against the GMC in the 5th Shipman Report issued by Dame Janet Smith.

The main recommendations in the *Good Doctors, Safer Patients* document included:

- The creation of unambiguous, operationalised standards for generic and specialist practice to give a clear, universal definition of a "good doctor" and to allow patients, employers and doctors themselves to have a shared understanding of what is expected of doctors. These standards would be incorporated into the contracts of doctors.

- Devolution of some of the powers of the GMC, as statutory regulator, to the local level. This would be accomplished through the creation of a network of trained and accredited General Medical Council affiliates.

- The creation of an independent tribunal in order to adjudicate on fitness to practise matters – the GMC would focus on the assessment and investigation of cases.
- A renewed focus on the assessment, rehabilitation and supervision of doctors with performance problems where these problems are not borne of malice.

- Greater public and patient involvement – to ensure public and patients work with GMC affiliates in making decisions around fitness to practise, and with medical Royal Colleges in the process of recertification.

- A new twin-track system of revalidation – relicensing for all doctors and re-certification for those on the specialist and GP registers.

These principles were adopted in the government's White Paper on professional regulation, *Trust Assurance and Safety – The Regulation of Health Professionals in the 21st Century* in February 2007.

Renewed attempt at introducing revalidation (2009)

Following on from the July 2006 *Good Doctors, Safer Patients* report by Liam Donaldson, an extensive consultation period was undertaken, resulting in a new document *Medical Revalidation: Principles and Next Steps* issued by a group led by Liam Donaldson.

Revalidation would be made up of two strands: Relicensing and Recertification.

Relicensing
The relicensing process was designed to ensure that doctors practise in line with the standards set out by the GMC. It consists mainly of annual local appraisals relying upon multi-source feedback.

One problem was that the NHS appraisal process as it stood was inadequate. In addition, it would also be inappropriate to impose a unique appraisal system when there is such diversity of work, settings and practices within the system. As a result, it was concluded that the appraisal process may indeed be designed by each employer for its own needs but that it should contain one standardised module agreed by the GMC. This would ensure that the process is appropriate for each doctor and simultaneously fulfils the GMC's criteria.

Relicensing was formally introduced in November 2009.

Recertification

The principles used to recertify doctors were to be set out by the appropriate Royal Colleges and specialist associations. The evaluation process would, of course, vary between specialties and may involve simulators, etc. It was recommended that "high-stakes" tests should be avoided, which effectively means that doctors won't be assessed with just one test but across a series of tests.

Because relicensing deals with the general standards whilst recertification deals with the specialist standards, both would be combined in one single recommendation to the GMC as to whether a doctor should be revalidated or not.

Recertification was meant to be introduced in 2010 but implementation was delayed until late 2012 as Royal Colleges struggled to arrive at a consensus on how to recertify their members. The main hurdles to implementation were:

- Logistics: There were 150,000 doctors who needed to be revalidated every 5 years. Trusts and the GMC would need to make sure that the revalidation steps were timed appropriately to avoid bottle-necks. There may be a challenge with doctors who come in and out of the system (e.g. maternity, fellowships, any non-clinical practice, etc).

- Method: Because the process will be driven locally, it would be challenging to ensure that it is applied consistently.

- Connecting: There would be a need to ensure that the revalidation process was linked to other processes of quality assurance, patient safety and quality improvement (e.g. audits, patient quesionnaires, etc.).
- Information: Appraisals and recertification would require the ready availability of a large amount of data. Care would need to be taken that the data is available.

- Cultural: Doctors would need to buy into the process and should not view it as a threat. Simultaneously, patients should not view the process as a smoke screen.

Revalidation at last! (Late 2012)

The process
Revalidation started on 3 December 2012 and the majority of licensed doctors in the UK are expected to revalidate for the first time by March 2016. Revalidation consists of regular appraisals with the employer, based on the GMC's *Good Medical Practice*.

- Licensed doctors are required to link to a Responsible Officer.

- Licensed doctors need to maintain a portfolio of supporting information drawn from their practice which demonstrates how they are continuing to meet the principles and values set out in the Good Medical Practice Framework for appraisal and revalidation.

- Licensed doctors are expected to participate in a process of annual appraisal based on their portfolio of supporting information.

- The Responsible Officer makes a recommendation to the GMC about a doctor's fitness to practise, normally every 5 years. The recommendation is based on the outcome of a licensed doctor's annual appraisals over the course of 5 years, combined with information drawn from the clinical governance system of the organisation in which the licensed doctor works.

- The GMC's decision to revalidate a licensed doctor is informed by the Responsible Officer's recommendation.

The portfolio
The portfolio needs to contain the following information, which should be discussed at the appraisal:

- General information such as personal details, scope of work, record of annual appraisals, personal development plans and their review, statement on probity and health.
- CPD record.
- Review of your practice including quality improvement activities such as clinical audit, review of clinical outcomes or case review; and description of significant events.
- Feedback on your practice including colleague and patient feedback, as well as a review of complaints and compliments.

Pros of revalidation
- Formalises practices which may have been done on an ad-hoc basis previously.
- Ensures compliance with some basic requirements and provides focus for the appraisal process.

Cons of revalidation
- Will not stop another Shipman.
- Senior clinicians may see it as their way to fulfil their management responsibilities and may consequently not ensure proper management of individuals at other times of the year.
- Runs the risk of identifying underperformance only at the "once-a-year appraisal point", i.e. in some cases too late.
- The process may require information that Trusts do not hold (e.g. for surgeons, individual results).
- It takes time to gather the information. Various organisations estimate that doctors will need approximately 2 hours a week to comply with requirements. This could prove tricky if Trusts cut down the time doctors can spend on non-clinical activity in order to maintain efficiency and profitability.

11 Communication station

Communication/role-play stations have become increasingly common at interviews in many specialties. They are based on realistic scenarios, with the patient being played either by an interviewer or a professional actor. Role plays are designed to test your communication skills more than your clinical skills – though inevitably a relevant clinical knowledge is essential to perform well – and the marking schemes reflect this, i.e. if you have excellent communication skills but talk rubbish, you will not pass the station.

The marking scheme

A variety of marking schemes have been used for communication/ role-play stations in the past. Typically, two interviewers would assess the candidate on a range of communication criteria. Each criterion is marked independently on a scale from 0 to 4, with 0 = Poor and 4 = Excellent and comprehensive. All marks are then added across all criteria and both interviewers to form the final mark. In some cases, the actor is also asked for their opinion on their feelings about the candidate from the point of view of the patient. A typical marking scheme would look as follows:

	Interviewer 1	Interviewer 2	Total mark
Setting the scene	0 to 4	0 to 4	0 to 8
Listening abilities	0 to 4	0 to 4	0 to 8
Verbal communication	0 to 4	0 to 4	0 to 8
Non-verbal communication	0 to 4	0 to 4	0 to 8
Content	0 to 4	0 to 4	0 to 8
Overall impression	0 to 4	0 to 4	0 to 8
Total	**Max score 24**	**Max score 24**	**Max score 48**

Criteria will vary in their wording and in the manner in which they are grouped (e.g. in some LETBs/specialties, verbal and non-verbal communication are marked together) but the expectations and overall criteria are the same.

Timing and preparation time

The actual consultation time will vary between 8 and 20 minutes depending on the LETB and specialty.

In most role-play stations you will be given some time to prepare. This varies from a few minutes to up to 20 minutes. Make sure you make the best use of that preparation time to read the brief given to you and the patient's history so that

- you do not miss any crucial information during the consultation; and
- you do not waste time during the consultation asking the patient about information that you have been told you already know. Some actors may have been instructed to act angry if they have to repeat information which is in the brief.

Running the role play

In order to score well, you will need to ensure that you address the following:

Understanding of the impact of the environment on the consultation
In some role plays, the room will be set up with the doctor's and the patient's chairs in a position which may not be ideal to build a rapport with the patient. If you feel it appropriate, you may want to move your chair and the patient's chair so that they are at an appropriate distance. If there is a table, you should ensure that you are not sitting across the table from the patient but that you are only separated by a corner of the table. Explain you have passed your bleep to someone else and do not expect to be disturbed during the consultation/meeting.

Introduction
Greet the patient by name if the brief gives it to you. Introduce yourself by name. Shake their hand if the patient is willing to accept and take the patient to the seat reserved for them (some actors may be instructed to remain standing until you invite them to sit down. If the situation warrants it, ask if they have come accompanied and if they want their relative or friend to sit in on the conversation. If you have been given a task (e.g. breaking bad news), then start by giving an overview of how the conversation will run, how long for and say that you will end with a clear, agreed management plan. If you or the department has caused the patient some harm, it is important to start with an apology.

Encourage the patient to tell you about the problem using open questions such as "What can I do for you today?" If the patient has been recalled to see you for a specific purpose, you can start more directly by explaining the reason for the recall.

Listening & Empathy
When discussing the issue at stake with the patient, allow the patient time to talk. Do not interrupt them unless you feel that you really need to. There are times when one needs to learn to keep quiet.

Be attentive to what they are telling you. The actor will have been primed to drop certain clues into the conversation, either voluntarily or taking one of your questions as a cue. In role play, candidates are often so obsessed with what they should do next that they sometimes forget to listen to the patient.

Throughout the conversation, observe the patient's behaviour. Listening does not necessarily mean hearing their words. You can pick up a lot of information by observing their body language. An awkward body language may give you clues about something that the patient is not telling you or is feeling embarrassed or scared about.

If the patient is silent or uncommunicative, encourage them by asking open questions. If the patient is distressed, it may also prove valuable to simply allow the situation to remain silent for a while if talking does not help. This may help them regain their composure.

History taking, diagnosis and clinical information
Ask all questions relevant to the scenario and explain any necessary points. Try not to ask for information that you should already know from the brief as you may irritate the patient. However, if you feel the need to confirm some information with the patient, either because the brief is ambiguous or the patient has contradicted information that you were given, then you may double-check.

Explain your diagnosis to the patient (including any differentials). Use words which are appropriate for the patient. Ensure that the patient understands what you are explaining; if necessary ask them to confirm their understanding by repeating in their own words what they have understood and by using questions such as "Is there anything that you do not understand?" or "Is there anything that you would like me to clarify?" If appropriate, explain using different methods or media (some spare paper may be made available to you).

Do not go into overdrive on the clinical section of your consultation at the expense of everything else. Clinical management accounts for, at most, 20% of the overall mark.

Holistic & psychosocial needs
The interviewers will be testing your ability to identify the various needs of the patient and how you address them during the consultation. Consider the physical aspects of the problem, but also the psychological and social sides. How is the patient coping? What is the impact on their family? What support is available to them? Make sure that you elicit the patient's ideas, concerns and expectations.

Body language
The manner in which you attempt to build a rapport with the patient and the appropriateness of your body language play an important role in your success at handling any role play. Make sure that you keep an open posture (no crossed arms), avoid being above or too close to them, lean slightly forward to show empathy when required, nod in the right places and, most important of all, maintain good eye contact with the patient to maintain that crucial rapport. Eye contact will also enable you to read the patient's emotions and possible discomfort, which could provide valuable clues. If they look

like they may cry, a hand on their hand or shoulder may be appropriate or you could pass them some tissues.

The unexpected
Some role plays are fairly mainstream (i.e. they attempt to replicate a normal consultation or scenario without any particular surprises). Others have twists and turns, which may catch you off-guard. This may include a patient who suddenly becomes irate, a patient who suddenly withdraws, refuses to say any more and looks down, a patient who cannot speak a word of English, or a patient who takes you onto a completely unexpected path.

When this happens, you must always remember that it is a game, i.e. this was planned. Rather than give up, try to remain calm and see how you can help the situation along. If the patient has walked out, see if you can get them back by using a more diplomatic approach. If the patient is not talking, don't just look at the examiners in despair; see if you can re-engage. If the patient throws you off-guard by mentioning issues that you were not expecting, don't look flustered or stunned. If you are, then ask the patient to elaborate on what they have just said; it will give you some time to regain your composure (and might help you score some listening points). If a patient is angry, slow down the speed of your conversation and become quieter; hopefully they will match you.

Ending the consultation

Role plays can be conducted in different manners. In some cases, the interviewers will let you know when you have 2 minutes left, but in many cases they won't. The first you will hear from them is the sound of a bell and a "thank you – you can move to the next station" grunt. Make sure that you keep track of time so that, if possible, you can draw the conversation to a natural close. Most marking schemes will include an allowance for your conclusion so make sure you get there. If you feel that you are likely to run out of time because you went off on a tangent or allowed the patient a bit too much space, then make a quick assessment of the situation and determine whether it is worth sacrificing 1 mark for not having a conclusion but gaining several more marks by addressing several other important issues instead.

Towards the end of the consultation, you should summarise to the patient what action is being proposed and what they have agreed to. You should also explain whether follow-up will be required and when. Thank them for coming and escort them to the door.

If your role play is over 20 minutes and you have finished before the end of the official period, ask yourself whether you have forgotten any important aspects and cover these as necessary. If not, then don't be afraid of terminating the exercise a few minutes early. It is better to end on a confident note than to waffle on for 2 minutes to kill time.

Examples of role plays

Topics will obviously vary per specialty but here are some examples of role plays which were part of recent interviews. I have stated the specialties in which they were asked, but some of these could be asked in many specialties.

- O&G: Explain to a patient who can only speak very little English that she has an ectopic pregnancy and needs an urgent procedure. The patient does not understand what you mean and is begging you to save the baby.

- Diabetes: A recently diagnosed patient explains that she does not trust her GP to have made the correct diagnosis about her diabetes. She is a single mother who makes ends meet by driving a taxi part-time.

- A&E: You diagnosed a patient with dyspepsia. He later died following an MI. You are now being confronted by an angry widow.

- Oncology & General Surgery: A patient was recently diagnosed with breast cancer. She is now refusing treatment and would like to opt for homeopathy instead.

- Dermatology: You recently reassured a patient that their mole was non-malignant. The patient returns to you, having sought a second opinion from another hospital, and accuses you of incompetence. A preliminary investigation showed that you had mixed up two biopsy results with two patients of the same name.

- Psychiatry: An old lady with dementia who lives in a care home presents to A&E with bruises. The A&E consultant leaves you on your own with the patient.

- Ophthalmology: Explain to an educated patient what glaucoma is. Once you have provided your explanation they express extreme fear at the prospect of becoming blind.

- CMT/Surgery in general: You are meeting the relative of an elderly woman, who is expressing concerns at the news she has read on MRSA in the NHS. Your hospital has a very good record and very low morbidity/mortality rate associated with MRSA but the relative has just spotted that the consultant's tie was brushing against all patients.
- Surgery: Break the news to a male patient that he has colorectal cancer. He is a fit athlete.

- Paediatrics: You requested a CT scan for a young patient. The radiologist has refused to do the scan due to the excessive radiation the child would be exposed to. The parents are blaming you for the lack of progress in the management of the patient.

- Paediatrics: Explain to a child what asthma (or diabetes) is.

12 Presentation station

Presentations are a recruitment tool that is on the increase. They have been a common feature at consultant interviews for some time and have recently found their way into ST recruitment.

What is being assessed?

Through your presentation, the interviewers will be assessing:

- Your general presentation skills (confidence, ability to engage an audience, etc.)
- Your ability to communicate your ideas clearly, concisely, using an approach suited to the topic and the audience. This will include marks for the clarity of the slides and their relevance
- The content of the presentation, i.e. the appropriateness and maturity of the content
- Your time management and organisational skills, i.e. your ability to stick to time, to allocate appropriate timing to each of the sections in your talk, etc.

Similar to the communication/role-play station, the marking scheme is likely to score each of the above out of 4, the combined marks of the two assessors forming the candidate's final score.

Preparation time and duration

Presentations generally vary in length between 5 and 10 minutes. Whilst in some specialties you may be asked to prepare a presentation in advance (the details being communicated to you in the invitation letter), in others you are likely to be placed on the spot, with the presentation topic being given to you just 45 minutes before you are due to present. Slides or overheads are usually allowed, though some restrict their number, whilst others require you to speak without visual aids. It is important to clarify the equipment that will be available on the day and then have several failsafe backup options. We have all seen people fail to get their projector working, even at national meetings. Ways to bring digital media include: CD, memory stick, uploaded to the web or emailed to the department. It may be worth copying onto transparencies for an overhead projector or bringing handouts.

Example of topics

Presentation topics are very varied. They generally fall under three different categories:

Generic
- Tell us about yourself
- What can you contribute to this specialty?
- How do you see your career developing, what skills do you have and which would you wish to gain?
- Why do you think you will make a good paediatrician/ orthopaedic surgeon?

Political
- How do current NHS changes impact on this specialty?
- How can this specialty become more efficient?
- How will you make sure that you become a good consultant when working hours are being decreased?

Personal
- Tell us about your hobbies.
- How have your strengths and weaknesses informed your career choice?

Occasionally, you may be asked to talk about some non-work-related topic of your choice. This has led to candidates making presentations on topics as varied as:
- How to teach cricket to 10-year-old children
- How to fly a helicopter
- The history of chocolate

Essentially, presentations can be regarded as extended interview questions, which you have 10 minutes rather than 2 minutes to answer. In that sense similar principles apply with regard to the need to structure the information around three or four themes or ideas and the need to make the information memorable by giving examples. There is nothing worse than a presentation which is too theoretical. Relate it to your audience.

Key principles

There are a few rules that you will need to remember during your preparation.

Keep the number of slides to a minimum
The rule of thumb is to have no more than 1 slide per 90 seconds of talk. Therefore, a 10 minute presentation should contain no more than six or seven slides. If your talk is organised around four central ideas (as it should be), then you would only need 1 slide for each plus an introduction and a summary slide, making six slides in total.

Keep the slides short and simple – the 4 by 4 rule
Never forget that the slides are there to support your presentation and help your audience. They are not there to replace your notes because you can't be bothered to learn your talk. If the slides are too busy then the interviewers will struggle to read them and to listen to you at the same time. The best slides are those which stick to the main principles and allow the audience to focus their attention on the candidate. As a general rule, you should have no more than 4 bullet points, each with no more than 4 words (this is called the 4 by 4 rule).

You should also ensure that any text written on the slides is large enough to be seen from a distance. You may want to ask beforehand whether the slides will be projected onto a screen (even if through an overhead projector) or simply read from a laptop. Whatever method they choose, your slides should be readable from a laptop screen which is 3 metres away. If they are not then there is either too much text or the font size is too small. Generally have high contrast between text and background (e.g. black on white or white/yellow on dark blue).

Vary your slides and make them accessible
Always think whether there is a more interesting way of representing your message than through a standard bullet point. For example, if I want to convey that there are four issues that the NHS is focusing on currently, I could simply list them as bullet points, for example:
- Efficiency
- Training
- Quality
- Profitability.

Alternatively, I could convey the same with four pictures on my slide:
- Efficiency: a picture of an organised or a chaotic unit
- Training: a picture of a ward round, or of a lecture
- Quality: a picture of a "tick"
- Profitability: a picture of a money bag or a pound sign.

Pictures, graphics and other means of visual representation are often very powerful and, in the meantime, your audience does not spend hours trying to decipher whole lines of text written in font size 8 in a desperate bid to make it all fit onto the page. Some of the best presentations I have seen included one candidate who used pictures only, no words, and a candidate who simply opted to use no visual aids. The effect it had was that the interviewers could then pay full attention to his talk. It is worth checking whether slides are essential (i.e. whether their quality will be judged) or whether they are just accepted, as this may give you ideas for how to make your talk more interesting. Try to avoid being too flashy or using complicated animations, transitions and movies, even if you are an expert. The interviewers are likely to use an old version of Windows, an old version of Microsoft Office and a slow computer.

Prepare a good speech, rehearse and take your time to deliver it

At the risk of stating the obvious, you must make sure that you rehearse your presentation many times so that you know it well, even without any visual aids. You should rehearse the presentation at least four times, two of which should be under time pressure, ideally in front of a scary panel!

Your speech, and not the slides, should be the main focus of the presentation. If you have prepared your visual aids properly, there should still be plenty of information that you need to add to your presentation verbally. Your speech will bring colour to your presentation, will bring personal reflection onto your ideas and will guide the audience through their journey of discovery.

As a rule, you should allow approximately 160 words per minute of speech. If you have to speak too quickly to get to the end of the presentation within the allocated time then you have too much information. Go back to the drawing board and see if all the information that you are presenting is relevant. If it isn't relevant or if it confuses matters then take it out. Be ruthless: the simpler the presentation, the better. Often the problem is linked to a lack of proper structure or the wrong structure. See if you can reorganise the information using different headings. Having more complex slides also increases the risk of you being out of synch with them and that is confusing for the audience.

Prepare some notes

During the presentation itself, it is preferable that you do not use notes. The danger of using notes is that you will inevitably be tempted to look at them. Also, reading them will make you sound wooden. However, you should bring a set with you just in case you have a memory gap. Make sure that they are hidden from you in your jacket pocket and that they are in a suitably small size (i.e. postcard size rather than A4) so that you can just pull them out of your pocket if need be without looking too flustered.

Watch your voice & delivery

- Your voice must be confident and normally loud.
- Avoid dropping your voice at the end of your sentences.
- Pause briefly between each slide. You might know your topic well but your audience will need time to keep up with you.
- Find good ways to link the slides.
- Do not rush your delivery.

Watch your body language

- Smile! Even a nervous smile is more endearing than a depressed or terrorised look.
- Adopt a natural stance. This means having your feet 25cm apart with your knees very slightly bent. Relax your shoulders.
- Be aware of your natural habits. Some people have a tendency to play with loose change in their pockets, to sway from one foot to the other, to play with a pen or their watch strap. You must be able to identify those habits and squash them before someone on the panel finds them irritating.
- Keep your hands in front of your belly. You can move them but not in an exaggerated fashion.

How to prepare

A common problem with presentations is the lack of clarity and simplicity in the message that the candidates want to convey. This results in complicated and confused slides, which then translates into a poor delivery. To perform well, you will first need to make sure that you have your story in the right order. Once you have looked at the topic, start talking about it in your head or aloud and see what comes out. Once you have perfected the story, you will be much better able to identify the key points that form its structure and its logic. Those points will form the backbone of your presentation and will dictate your slides. If you commit your thoughts too early to paper or to slides, you will lose flexibility. You will be reluctant to change the order of your slides or review the entire structure of your talk for fear of having wasted your preparation time. Not committing your talk to paper too early will enable you to adopt a totally different approach without having to rewrite a lot of material. Try to reframe from another's point of view. Try taking a system (helicopter) view or see the topic from the point of view of a commissioner or a patient or the panel themselves. What would be important or interesting for each of these stakeholders?

13 Group discussion station

Group discussions are gradually being introduced in several specialties, though they are still fairly uncommon outside General Practice recruitment.

Format of the group discussion

Group discussions typically last 20 minutes. There will usually be four people in each group, sitting around a table, with each being assessed by an external observer. In some cases, there may be just one observer for two candidates. The team is given a brief shortly before the session commences and, at the agreed time, the required discussion needs to start.

There are two main types of group discussions:

- ***Normal discussion***
  The group is given a general topic of discussion and has to debate the issues involved. In many cases, the discussion is based on a simple 2-line brief such as an ethical issue. In other cases, the information provided is more comprehensive and may include, for example, a letter of complaint addressed to your consultant or extracts from patient notes. In other, more complex group discussions, the candidates may actually be given different pieces of information; for example, one candidate may have a summary of the notes, another candidate will be given a complaint letter, another an abstract from a report, etc.

- ***Role-play group discussion***
  In this type of group discussion, each candidate is allocated a different role. One candidate may be playing the SHO, another candidate a senior nurse, another candidate the GP and the fourth candidate a social worker. The roles obviously depend on the type of scenario given.

What the assessors are looking for

Much as it is tempting to show off your knowledge of the topic being discussed, this is only one of the areas that the assessors will be looking for. Indeed, if they wanted to test your knowledge, they would either ask you a direct question in a normal interview setting or ask you to do a presentation.

The assessors will, however, be far more interested in the manner in which you interact with the rest of the group. This can be very complex to assess when people can have such diverse personalities. Some candidates will be natural leaders and they may well feel at ease driving the conversation. Other candidates may be good facilitators, i.e. they get on well with most people and are able to keep the peace. Others still may contribute much to the team by generating content and ideas but could not lead or facilitate.

What the interviewers will be looking at therefore is a general pattern of behaviour that fits well within a team and your interaction with others, whatever your personality. This will include

- Your general contribution to the discussion (which can include active listening, support of others and encouraging opinions from the quieter members)
- Your problem-solving abilities
- Your general interaction with others including your body language and the appropriateness of your behaviour (empathy, sensitivity, situation awareness)
- Your ability to cope with the challenges of working within a team (e.g. pushy colleagues, uncooperative people, quiet people, etc.)
- Clarity of communication and assertiveness if necessary
- Your ability to influence/negotiate with people, i.e. to rally people to your point of view without making them feel coerced.

Dealing with difficulties within the group

Going round in circles
There may be a time when the conversation has ceased to be productive and the team has either gone off on a tangent or is caught in a vicious circle. In such cases, you would score marks for enabling the team to get back on track by gently reminding everyone of the original goal and pointing out in a non-threatening manner that you all got lost. Bring the focus back to the patient, to avoid making things confrontational.

Awkward silences
The team may have reached a natural break in the discussion, or it may be that no one dares speak in case they say something stupid. If this happens, you should encourage the team to summarise the discussion so far, to set out the main themes that could be discussed and then to ensure that the points are dealt with systematically. If the conversation has ended because all points were discussed, then finish the exercise early; do not go on waffling until the bell rings.

Overbearing colleagues
Some talk a lot because they are extroverts; extroverts tend to think while they talk and may actually change their opinion 180 degrees very quickly. Others may talk a lot due to nerves. There will always been one in the group who will have misunderstood the point of the exercise, thinking that he will look clever by showing off his knowledge of the topic being discussed. Such people can do themselves much damage but can also take you down with them if you are not careful. Indeed, by occupying the space and monopolising the time available, they do not allow you the platform that you need to show off your own team-playing skills.

If you are that person, then make sure you allow others to have a say and encourage them. If you are faced with such a colleague, the best way to handle the situation with different strategies is:

- Asking others what they feel about what this person has said
- Asking for a break in the discussions so that you can summarise the points made so far
- Directly letting the colleague know that it would be useful for others to comment so that you can get different perspectives on the problem.

Silent colleague
Some are silent because they are introverts, doing lots of thinking in their heads and then waiting to give a considered answer. Ask them directly and wait for 7-8 seconds for a reply. Others may just feel uncomfortable with the role-play technique, be anxious as it is part of the interview or just not know the answer.

By themselves silent colleagues may not feel like a threat because they give you the floor. But in fact, if you ignore them and do not encourage them, you may be marked down. Pay attention to those around so that you can spot them.

If you are that person then you will need to make an effort to participate, at least by encouraging others. No silent candidate will score anything. If you want to demonstrate that you are a good listener then you will need to make sure that you demonstrate this not just by listening but also by summarising the points made so far and helping the team move forward.

If you are faced with a silent colleague, try to encourage them to participate by asking for their opinion at an appropriate moment. If they refuse to be involved, then do not force them as it would count against you but demonstrate at least that you are making an effort.

14 Power words

The vocabulary and turns of phrase that you use at an interview will make a big difference to the way in which your answers are perceived by the interviewers and the confidence and maturity that you exude.

Part of your maturity and confidence will come from the spontaneity and fluency of your answers, both of which can be addressed through practice, but much of it will come from using words which convey your meaning powerfully.

The impact of action and power words

Consider these sentences:
- I would be happy to play a role in teaching.
- I have been lucky to be involved in audit over the past two years.
- I have had the opportunity to be involved in research.
- My consultant has asked me to be involved in research.
- I have been part of a team which developed guidelines on <xxx>.

None of these really convey a strong sense of commitment and enthusiasm. At an interview, saying such sentences would be okay in small doses, but if repeated too often they will give the feeling that you are not in control of your career and that you are adopting a passive stance.

- "I would be happy" basically means "Ask me nicely and I would do it".
- "I have been lucky" conveys that you did not choose to get involved but that you rely on others to give you opportunities.
- "I have had the opportunity" makes you rely on the chance that someone (or fate) will create an opportunity where you can get involved.
- "My consultant has asked me" may be what actually happened but again it makes you look dependent and not in charge of your destiny.
- "I have been part of a team" may be okay as an introduction if you then go on to talk about yourself but does not convey your own role and, as such, runs the risk that you may be selling the achievement of the team rather than your own.

There are tighter, more assertive and more powerful ways of selling yourself by using what is termed "power" or "action" words. For example:
- "I have developed a strong interest in teaching and am very keen to take on a more prominent role over the next few years."
- "I have played a key role in managing audit projects from data collection to presentation stage."
- "I discussed with my consultant a number of research opportunities, following which I embarked on a project which looked at <xxx>"
- "I reviewed our morbidity rate following procedure <xxx> and, as a result, I worked closely with two of my colleagues to introduce new guidelines on <yyy>."

These power words will help you convey your meaning in a more distinct manner and will make a lot of difference to your final mark.

List of action and power words

Here is a list of over 500 power words that you can use to increase the strength of your answers. These can be used not only in formal interview questions but also in role play and group discussions.

Abbreviated	Abolished	Abridged	Absolved
Absorbed	Accelerated	Acclimated	Accompanied
Achieved	Acquired	Acted	Activated
Actuated	Adapted	Added	Addressed
Adhered	Adjusted	Administered	Admitted

Adopted	Advanced	Advertised	Advised
Advocated	Affected	Aided	Aired
Allocated	Altered	Amended	Amplified
Analysed	Answered	Anticipated	Applied
Appointed	Appraised	Approached	Approved
Arbitrated	Arranged	Articulated	Ascertained
Asked	Assembled	Assessed	Assigned
Assisted	Assumed	Attained	Attracted
Audited	Augmented	Authored	Authorised
Awarded	Balanced	Began	Benchmarked
Benefited	Bid	Billed	Blocked
Boosted	Borrowed	Bought	Branded
Bridged	Broadened	Brought	Budgeted
Built	Calculated	Canvassed	Captured
Cared	Cast	Catalogued	Categorised
Centralised	Chaired	Challenged	Changed
Channelled	Charged	Charted	Checked
Circulated	Clarified	Classified	Cleared
Closed	Coached	Co-authored	Collaborated
Collected	Combined	Commissioned	Committed
Communicated	compared	Compiled	Completed
Complied	Composed	Computed	Conceived
Conceptualised	Condensed	Conducted	Conserved
Consolidated	Constructed	Consulted	Contacted
Contributed	Controlled	Converted	Conveyed
Convinced	Coordinated	Copyrighted	Corrected
Corresponded	Counselled	Created	Critiqued
Cultivated	Customised	Cut	Dealt
Debated	Debugged	Decentralised	Decreased
Deferred	Defined	Delegated	Delivered
Demonstrated	Depreciated	Described	Designated
Designed	Detected	Determined	Developed
Devised	Diagnosed	Directed	Discovered
Dispatched	Dissembled	Distinguished	Distributed
Diversified	Divested	Documented	Doubled
Drove	Earned	Eased	Edited
Educated	Effected	Elicited	Eliminated
Emphasised	Empowered	Enabled	Encouraged
Endorsed	Enforced	Engaged	Engineered
Enhanced	Enlarged	Enlisted	Enriched
Ensured	Escalated	Established	Estimated
Evaluated	Examined	Exceeded	Exchanged
Executed	Exempted	Expanded	Expedited
Experienced	Explained	Explored	Exposed
Extended	Extracted	Fabricated	Facilitated
Fashioned	Fielded	Financed	Fired
Flagged	Focused	Forecasted	Formalised
Formatted	Formed	Formulated	Fortified
Founded	Fulfilled	Furnished	Furthered
Gained	Gathered	Gauged	Generated
Governed	Graded	Granted	Greeted
Grouped	Guided	Handled	Headed
Helped	Hired	Hosted	Identified
Ignited	Illuminated	Illustrated	Impacted

Implemented
Improved
Improvised
Inaugurated
Incorporated
Increased
Incurred
Individualised
Indoctrinated
Induced
Influenced
Initiated
Innovated
Inquired
Inspected
Inspired
Installed
Instigated
Instilled
Instituted
Instructed
Insured
Integrated
Interacted
Interpreted
Intervened
Interviewed
Introduced
Invented
Inventoried
Invested
Investigated
Invited
Involved
Isolated
Issued
Joined
Judged
Justified
Kept
Launched
Lectured
Led
Lightened
Liquidated
Litigated
Lobbied
Localised
Located
Logged
Maintained
Managed
Manufactured
Mapped
Marketed
Maximised
Measured
Mediated
Mentored
Merchandised
Merged
Minimised
Modelled
Moderated
Modernised
Modified
Monitored
Motivated
Moved
Multiplied
Named
Narrated
Navigated
Negotiated
Netted
Noticed
Nourished
Nursed
Nurtured
Observed
Obtained
Offered
Opened
Operated
Orchestrated
Ordered
Organised
Oriented
Originated
Overhauled
Oversaw
Participated
Patented
Patterned
Performed
Persuaded
Phased
Photographed
Pinpointed
Pioneered
Placed
Planned
Polled
Posted
Prepared
Presented
Preserved
Presided
Prevented
Processed
Procured
Produced
Proficient
Profiled
Programmed
Projected
Promoted
Prompted
Proposed
Prospected
Proved
Provided
Publicised
Published
Purchased
Pursued
Qualified
Quantified
Quoted
Raised
Ranked
Rated
Received
Recognised
Recommended
Reconciled
Recorded
Recovered
Recruited
Rectified
Redesigned
Reduced
Referred
Refined
Regained
Registered
Regulated
Rehabilitated
Reinforced
Reinstated
Rejected
Remedied
Remodelled
Renegotiated
Reorganised
Repaired
Replaced
Reported
Represented
Rescued
Researched
Resolved
Responded
Restored
Restructured
Resulted
Retained
Retrieved
Revamped
Revealed
Reversed
Reviewed
Revised
Revitalised
Rewarded
Safeguarded
Salvaged
Saved
Scheduled
Screened
Secured
Segmented
Selected
Separated
Served
Serviced
Settled
Shaped
Shortened
Shrank
Signed
Simplified
Simulated
Sold
Solicited
Solved
Spearheaded
Specialised
Specified
Speculated
Spoke
Spread
Stabilised
Staffed
Staged
Standardised
Steered
Stimulated
Strategised
Streamlined
Strengthened
Stressed
Structured
Studied
Submitted
Substantiated

Substituted	Suggested	Superseded	Supervised
Supplied	Supported	Surpassed	Surveyed
Synchronised	Systematised	Tabulated	Tailored
Targeted	Taught	Tested	Tightened
Took	Traced	Tracked	Traded
Trained	Transacted	Transcribed	Transferred
Transformed	Translated	Transmitted	Transported
Treated	Tripled	Troubleshot	Tutored
Uncovered	Underlined	Undertook	Unearthed
Unified	United	Updated	Upgraded
Urged	Used	Utilised	Validated
Valued	Verbalised	Verified	Viewed
Visited	Visualised	Voiced	Volunteered
Weathered	Weighed	Welcomed	Widened
Withstood	Witnessed	Won	Worked
Wrote	Yielded		